Arkansas IV-E Waiver Demonstration Project
Final Evaluation Report

PREPARED FOR
Arkansas Department of Human Services
Division of Children and Family Services

BY
Hornby Zeller Associates, Inc.
A Public Consulting Group Company
48 Fourth St., Suite 300
Troy, NY 12180

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Executive Summary

The Arkansas Department of Human Services (DHS), Division of Children and Families Services' (DCFS) IV-E Waiver Demonstration Project sought to improve outcomes related to safety and permanency for children and their families. The Waiver provided an opportunity to build upon several initiatives within the child welfare system that had already been underway, including the scaling up of effective screenings, assessments, and interventions, and the shift from a reliance on generic interventions to evidence-based and evidence-informed practices and programs (EBP and EIP). The Waiver was also designed to strengthen the ongoing implementation of the goals and guiding principles of the DCFS Practice Model through a comprehensive expansion of practice beginning at the investigation phase and continuing through post-reunification services and/or legal permanence.

The goals of the Arkansas Title IV-E Waiver Demonstration Project are as follows:

1. To safely reduce the number of children entering foster care;
2. To increase placement stability; and,
3. To expedite permanency for children in foster care.

To achieve these goals, DCFS selected six initiatives for statewide implementation:

1. Differential Response (DR)
2. Team Decision Making (TDM)
3. Nurturing the Families of Arkansas (NFA)
4. Targeted Recruitment (TR)
5. Child and Adolescent Needs and Strengths (CANS) and the Family Advocacy Support Tool (FAST)
6. Permanency Roundtables (PRT)

To understand the impact of the Waiver on improving outcomes for children and families, three concurrent evaluations were used: a process evaluation, an outcome evaluation, and a cost evaluation.

Process Evaluation

The process evaluation was designed to examine three basic research questions:

1. What kinds of assessment and planning occurred in each county and/or Service Area prior to implementation of the initiative?
2. Were the practices/services implemented with fidelity to the selected evidence-based model and/or in the manner intended?

3. To what extent was each of the models implemented, *i.e.,* how many families and children received each of the interventions?

Outcome Evaluation

Three research questions were used to measure outcomes.

1. Were children in the experimental group families more likely than children in the comparison group families to remain safely in their homes?
2. Did children in the experimental group experience fewer moves from one setting to another while in care than did comparison group children? If so, to what extent can that be attributed to the initiative(s)? Which ones?
3. Did children in the experimental group attain permanency more quickly than children in the comparison group(s)? If so, to what extent can that be attributed to the initiative(s)? Which ones?

Cost Evaluation

The cost evaluation examined two research questions.

1. What is the average cost of serving a child/family in the experimental group compared to a child/family in the comparison group?
2. By the end of the waiver, to what extent has the relative share of DCFS costs attributable to in-home services changed?

Program/Policy Lessons Learned and Recommendations

Differential Response

Because Differential Response was in place in some Areas before the start of the Waiver period, the State enjoyed a relatively smooth implementation, adaptation of the initiative, and positive preliminary outcomes. Recommendations pertain to program training and capacity.

1. Consider implementing wider training initiatives on DR so that non-DR staff can provide back-up and/or support to DR Specialists. Currently, many non-DR staff are not aware of DR and how it fits into the larger goals of the agency.
2. Build awareness of DR within local communities so that stakeholders and partners can understand the purpose of DR as a program so that support and availability for common service needs can increase.

Team Decision-Making

The TDM initiative experienced delayed and partial implementation and encountered significant challenges that have impacted the success of the initiative. Recommendations speak to some of these challenges, while considering the political and logistical environments in which TDMs are implemented.

1. Staff buy-in and organizational readiness regarding when to create a protection plan and the purpose of the TDM have been challenges. The State can address this by developing and disseminating best practices for planning for and scheduling a TDM that highlight how a TDM can benefit a family. Staff who plan and participate in TDMs should be encouraged to build relationships with staff and community partners in order to increase likelihood of a TDM resulting in successful follow-up.

Nurturing the Families of Arkansas

NFA has been successfully integrated into services throughout the state, and staff and community partners are engaged and in support of the program. Recommendations for NFA pertain to capacity and eligibility criteria.

1. For future projects of similar scope, the State should develop a plan for increasing capacity to serve more families, especially if the goal is to serve all families with a need for a parenting program (who meet the criteria).
2. There have been conflicting messages regarding the eligibility criteria pertaining to substance use. Caregivers currently using substances were originally disqualified from receiving NFA. However, criteria have been softened to exclude only caregivers for whom substance use would interfere with successful participation in NFA; caregivers with less severe use would be permitted to join. This criteria change was not consistently or assertively messaged to DCFS staff (those making program referrals). The State should re-establish criteria guidelines and message consistently throughout all Service Areas.

Targeted Recruitment

The Targeted Recruitment initiative has experienced barriers related to staffing, including the hiring, role, and responsibility of Community Engagement Specialists, Area readiness, and project messaging. Programmatic recommendations pertain to project management and the need for discrete project goals.

1. Central Office staff should provide robust direction and guidance on how, when, and where Targeted Recruitment activities should occur, and should increase accountability measures to CESs.
2. The number of inquiries that come into the case management (or similar) system after a recruitment event occurs should be tracked. This information can be tracked at the county level to determine which events/strategies

work well in different regions across the state, since recruitment strategies change depending on the demographics of each region.

3. Customer service training should be provided to caseworkers in an effort to underscore the importance of rapid response to foster families for the retention of homes.
4. One or two staff should be hired to serve as a "Foster Parent Hotline," to respond to questions from foster parents about procedural questions (*e.g.*, how to fill out certain forms) or formal questions (*e.g.*, where is the closest day care).

Permanency Roundtables

The PRT initiative has experienced challenges in implementation and provision of services to the target population of youth in-care for 18 months or more and was ultimately discontinued. Data available on preliminary outcomes can be used to make informed programmatic changes and improvements. To the extent Permanency Roundtables are reconsidered for implementation, recommendations pertain to implementation planning and policy.

1. Guidelines for the age and circumstances of youth that should receive priority for a PRT should be refined, and how they may affect intended outcomes.
2. A standard number of PRTs that should be conducted each month or quarter based on each Service Area's percent of the statewide target population should be established.
3. Accountability and documentation requirements need to be established, along with a statewide plan for continuous quality review and improvement.
4. The State PRT Coordinator should not be required to attend each PRT throughout the state. This practice is not feasible or effective. Instead, more staff need to be trained in each Area to conduct meetings and fulfill PRT roles and responsibilities.

CANS/FAST

The CANS/FAST initiative has been implemented universally to children, youth, and families across the State, and the tool is being effectively used and documented in CHRIS. Recommendations for CANS/FAST are centered around communication and support.

1. Messaging on the use of the CANS/FAST as a communication tool needs to occur frequently, providing ongoing guidance on how the assessments differ from the FSNRA, the use of meaningful and pertinent comments, and how to gather necessary information about the family or child so that scoring for strengths and needs is done appropriately.

2. Training and recertification should increase and be improved. DCFS should consider offering interactive modules where staff can practice and receive feedback on assessment scoring. Support should be ongoing and throughout the year to keep staff skills sharp and to improve the accuracy and fidelity of the assessments. “Tiers” of support might also be considered so that less experienced or less confident staff can access more intensive support and guidance.

Evaluation Lessons Learned

Evaluation activities and findings of the Arkansas IV-E Waiver evaluation have shed light on key lessons learned, providing recommendations regarding evaluation design and implementation.

1. It was necessary to adapt and refine data collection protocols and their implementation according to the reality of project implementation, the extent to which initiative-specific details were documented, the availability of data in CHRIS, and the extent that available data could be used to answer research questions. For ARCCC in particular, it was found that focus groups were not the best medium to hear the voices of foster parents, but rather one-on-one interviews with each family which allowed for a more relaxed and comfortable environment for the families to attend on their own time.
2. There are an increasing number of opportunities to use evaluation findings to inform data-driven programmatic decisions. Evaluation design should continue to consider process and outcome evaluation questions that may have local significance and can be used to serve a specific function in program management or implementation design. For example, the CANS/FAST case review tools were redesigned to capture the process components of the assessment tools that were of considerable import to DCFS, that is, the extent to which assessments are completed using pertinent and meaningful information to the family or child. DCFS has its own process for gathering this information but redesigning the case review tool allowed for that process to be more uniform, semi-quantitative, and streamlined.
3. Not all components of the evaluation plan were executed within the first ten quarters of the Waiver period. In the upcoming year, efforts should focus on evaluating well-being for NFA and Targeted Recruitment and building a model for propensity score matching. Additionally, evaluation analysis should begin to capture the impact of the Waiver as a whole on targeted populations. As sample sizes increase, specific evaluation questions pertaining to the impact of receiving multiple Waiver initiatives should be explored.

4. As sample sizes for experimental cohorts increase, analyses conducted will increase in rigor. Cross tabulations and logistic regression models should be created so that the impact of initiatives on outcomes can be isolated.

Introduction

Background and Context

The Arkansas Department of Human Services (DHS), Division of Children and Families Services' (DCFS) IV-E Waiver Demonstration Project sought to improve outcomes related to safety and permanency for children and their families. The Waiver provided an opportunity to build upon several initiatives within the child welfare system that were already underway, including the scaling up of effective screenings, assessments, and interventions, and the shift from a reliance on generic interventions to evidence-based and evidence-informed practices and programs (EBP and EIP). The Waiver was also designed to strengthen the ongoing implementation of the goals and guiding principles of the DCFS Practice Model, provided below, through a comprehensive expansion of practice beginning at the investigation phase and continuing through post-reunification services and/or legal permanence.

DCFS Practice Model Goals

- Safely keep children with their families.
- Enhance well-being in all of our practice with families.
- Ensure foster care and other placements support goals of permanency.
- Use permanent placement with relatives or other adults who have a close relationship to the child or children, when reunification is not possible (preferred permanency option).
- Ensure adoptions, when that is the best permanency option, are timely, well-supported and lifelong.
- Ensure youth have access to an array of resources to help achieve successful transition to adulthood

DCFS Practice Model Principles

- Behavior change and the work of change is a part of our daily challenge.
- Safety for children is achieved through positive protective relationships with caring family and community members.
- Meaningful decisions require close family participation in decision-making.
- Strengths of families and supporting these strengths contribute to life-long permanent relationships for children.
- Families' success depends on community involvement and shared problem solving.
- Practice with families is inter-related at every step of the casework process.

- Sustainable success with families is the work of a team.
- The entire system must support frontline practice to achieve positive outcomes with families.
- Every staff position, role, and activity of the Division shows continuous effort to build and maintain professionalism.
- Skill-based training and consultation forms the foundation for successful practice with families.
- Quality improvement and accountability guide all of our work.
- How we do the work is as important as the work we do.

The State applied for Waiver funds in 2012 and received its award in 2013. While implementation began July 31st, 2013, as will be described, portions of the Waiver were not initiated until later periods.

The Purpose of the Waiver Demonstration

The goals of the Arkansas Title IV-E Waiver Demonstration Project are as follows:

1. To safely reduce the number of children entering foster care;
2. To increase placement stability; and,
3. To expedite permanency for children in foster care.

To achieve these goals, DCFS selected six initiatives for statewide implementation:

1. Differential Response (DR)
2. Team Decision Making (TDM)
3. Nurturing the Families of Arkansas (NFA)
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5. Child and Adolescent Needs and Strengths (CANS) and the Family Advocacy Support Tool (FAST)
6. Permanency Roundtables (PRT)

By implementing the interventions listed above, Arkansas anticipated it would enhance its child welfare system to be one that better values families by:

- Engaging families and encouraging them to have a voice in decisions regarding their cases;
- Serving children and families in their homes when possible;
- Working to ensure children's time in foster care is limited so that every child has timely permanence; and,
- Providing readily available services to help produce the best possible outcomes for the families served by the system.

Intervention Components and Target Populations

A description of each of the initiatives Arkansas chose to implement under the Waiver and their target populations is provided below.

Differential Response

Differential Response is a system reform that enables DCFS to appropriately meet the intensity of involvement for reports of child abuse and neglect. Rather than investigate all maltreatment reports, as had traditionally been done, DR shifts the approach of low-risk child maltreatment reports to a more family involved and family-centered approach. The family receives an assessment and services are provided based on what the family believes it needs. By linking families with needed services, DR aims to safely reduce the number of children entering the foster care system, decrease future involvement with DCFS, and return youth to their homes in the event a child is removed. The program does not place blame on the family and is short-term (cases are not to last more than 30 days, but two 15-day extensions may be granted, if necessary).

Team Decision-Making

Team Decision-Making meetings are held within 48 hours of a protection plan being put into place or upon the removal of a newborn in the instance of a Garrett's Law case. Family and extended family, friends, and informal supports are invited by the family to attend the TDM and brainstorm ways to keep the child(ren) safe. DCFS is involved mostly to ensure that the final plan, developed via the TDM participants, meets the Division's requirements for keeping the child safe. The rapid response and action plan are designed to safely reduce the number of children entering the foster care system and, in the event a child is needed to be removed, return youth to their homes by following the action plan.

Nurturing the Families of Arkansas

Nurturing the Families of Arkansas is Arkansas' version of the Nurturing Parenting Program, a program for parents/caregivers involved in in-home cases with children between the ages of 5-11. The age range was increased to include youth up to age 18 in the program in January 2018. NFA is being administered by MidSOUTH at the University

of Arkansas at Little Rock. The 16-week program is administered in groups and/or individually and is designed to build and strengthen positive parenting skills. By providing parents with improved parenting techniques, NFA aims to safely reduce the number of children entering the foster care system, decrease future involvement with DCFS, and return youth to their homes in the event a child is removed.

Arkansas Creating Connections for Children

Arkansas Creating Connections for Children (ARCCC) spearheads recruitment and retention efforts of foster and adoptive families throughout the State. DCFS is using the Annie E. Casey Foundation *Family to Family* model to enhance the recruitment and retention of resource families. Efforts include general recruitment, targeted recruitment of population groups that are underrepresented, and child-specific recruitment for children who may be harder to place. ARCCC was funded in part by the Waiver and in part through the Diligent Recruitment Grant. The Waiver (which targeted six Service Areas) and the Grant (which targeted the remaining four Service Areas) were designed to mirror each other exactly, although Grant activities were one year ahead of the Waiver.

CANS/FAST

The *CANS* and *FAST* tools replaced the Family Strengths, Needs, and Risk Assessment (FSNRA) that was previously used to measure the strengths and needs of children and their families. CANS assessments are designed for use with youth in out of home placements, with two unique tools created to assess the strengths and needs of children and youth, one for those ages 0–4 and a second for those five years of age and older. FAST assessments are designed for use with the entire family. DCFS believes that by improving the assessment of the strengths and needs of children and families over time, the CANS and FAST will identify the highest priority needs of clients so that appropriate services can be provided to improve child and family functioning. Improved functioning will, in turn, safely reduce the number of children entering the foster care system, increase placement stability and expedite permanency for children in foster care.

Permanency Roundtables

Permanency Roundtables are held for youth who have been in foster care for 18 months or longer, and support permanency planning and outcomes. The meeting involves the caseworker, supervisor, a permanency consultant, and other case-specific stakeholders. The PRT model (developed by Casey Family Programs) has a set agenda for the meetings. Each PRT results in a Permanency Action Plan and Permanency Action steps assigned to case stakeholders. The initiative was ultimately discontinued in 2016 due to a challenges implementing the service to the target population.

Overview of the Evaluation

To understand the impact of the Waiver on improving outcomes for children and families, three concurrent evaluations were used: a process evaluation, an outcome evaluation, and a cost evaluation.

Process Evaluation

The process evaluation was designed to examine three basic research questions:

1. What kinds of assessment and planning occurred in each county and/or Service Area prior to implementation of the initiative?
2. Were the practices/services implemented with fidelity to the selected evidence-based model and/or in the manner intended?
3. To what extent was each of the models implemented, *i.e.,* how many families and children received each of the interventions?

Outcome Evaluation

Three research questions were used to measure outcomes.

1. Were children in the experimental group families more likely than children in the comparison group families to remain safely in their homes?
2. Did children in the experimental group experience fewer moves from one setting to another while in care than did comparison group children? If so, to what extent can that be attributed to the initiative(s)? Which ones?
3. Did children in the experimental group attain permanency more quickly than children in the comparison group(s)? If so, to what extent can that be attributed to the initiative(s)? Which ones?

While safety and permanency are the overarching intermediate outcomes intended for the six initiatives, the CANS/FAST, Nurturing Parenting Program, and Targeted Recruitment also include well-being outcomes. Well-being was measured for the experimental and, where appropriate, comparison groups. Specifically, evaluation of well-being was used to determine if the child's behavioral, emotional and social functioning were maintained or improved and if the child(ren)'s needs were met in these areas. Indicators used in the Child and Family Services Review (CFSR) inform how to assess well-being for the Waiver and were applied to assess the actual status of the child (as opposed to the agency's efforts to address well-being issues).

Cost Evaluation

The cost evaluation examines two research questions.

1. What is the average cost of serving a child/family in the experimental group compared to a child/family in the comparison group?
2. By the end of the waiver, to what extent has the relative share of DCFS costs attributable to in-home services changed?

By answering these questions, the evaluation determined the extent to which the intended fiscal outcomes were achieved, and which program(s) was(were) most effective in reducing the overall costs to the agency in comparison to traditional services.

Theory of Change/Logic Models

Logic models for the initiatives were developed to illustrate the conceptual linkages between the Waiver activities and the measurable short-term and intermediate outcomes. Each logic model focuses on one initiative and the corresponding inputs, outputs, outcome linkages, and short-term and intermediate/system outcomes. Multiple logic models were constructed for initiatives designed to achieve more than one goal.

It should also be noted that long-term outcomes are not included in the logic models. Because most of the children for whom the project is successful will leave the system either upon achievement of the desired short-term or intermediate outcome or shortly thereafter, measurement of the longer-term outcomes, such as whether the youth will grow to be a productive adult, is unfeasible.

Differential Response

Differential Response ► Goal: Reduce the number of children entering foster care

Inputs	Outputs	Outcome Linkages	Short-term Outcomes	Intermediate/ System Outcomes
Families referred to DCFS for neglect Policy changes Staff increases Stakeholder education	Number of families diverted from investigation to assessment Number of families receiving informal supports Number of families	Differential Response engages families in a non-adversarial manner, connecting them to community resources and supports which will better enable the families to care for their children and thus lead to fewer children entering	Fewer children enter the foster care system • Number/ percent of families with no child removed within 90 days of the report date • Number/ percent of children not removed within 90 days of the report date	Reduction in the proportion of the State's children in foster care • Decrease in the number/ percent of children who are discharged from care within 90 days of entry[1] • Decrease in the number/ percent of children in foster care

[1] All applicable measurements exclude children who were in care for fewer than eight days.

Inputs	Outputs	Outcome Linkages	Short-term Outcomes	Intermediate/ System Outcomes
Evidence-based assessment Workers trained CHRIS enhancements	receiving services appropriate to needs	the foster care system.		six and 12 months after referral

Table 1. Differential Response GOAL: Reduce Number of Children Entering Foster Care

Team Decision-Making

Team Decision-Making ► Goal: Reduce the number of children entering foster care

Inputs	Outputs	Outcome Linkages	Short-term Outcomes	Intermediate/ System Outcomes
Families with safety factors present Staff increases Workers trained Evidence-based practices CHRIS enhancements	Number of families diverted from investigation to assessment Number of families receiving informal supports Number of families receiving services appropriate to needs	Team Decision-Making involves families in case decision-making which leads to more caregiver involvement and greater caregiver commitment to fulfilling the case plan, which in turn leads to fewer children entering foster care.	Fewer children enter the foster care system • Number/ percent of families with no child removed within 90 days of the first TDM • Number/ percent of children not removed within 90 days of the first TDM	Reduction in the proportion of the State's children that enters foster care • Decrease in the number/ percent of children who are discharged from care within 90 days of entry • Reduction in number/ percent of children in foster care six and 12 months after initial team meeting

Table 2. Team Decision-Making GOAL: Reduce Number of Children Entering Foster Care

Nurturing the Families of Arkansas

Nurturing the Families of Arkansas ► Goal: Reduce the number of children entering foster care

Inputs	Outputs	Outcome Linkages	Short-term Outcomes	Intermediate/ System Outcomes
inadequate parenting skills Evidence-based curriculum Staff increases	Number of families receiving NFA Number of families	Nurturing the Families of Arkansas Program leads to improved parenting skills which leads to fewer children entering foster care	Fewer children enter the foster care system • Number/percent of caregivers with higher scores on the process and post	Reduction in the proportion of the State's children in foster care • Decrease in the number/ percent of children who are discharged from care

Inputs	Outputs	Outcome Linkages	Short-term Outcomes	Intermediate/ System Outcomes
Workers trained Contracted providers	successfully completing NFA Number of NFA lessons that the families attends		assessments than the pre-assessment • Number/percent of families with no child removed within 90 days of NFA initiation • Number/percent of children not removed within 90 days of NFA initiation	within 90 days of entry • Reduction in number/ percent of children in foster care six and 12 months after of NFA referral

Table 3. Nurturing the Families of Arkansas GOAL: Reduce Number of Children Entering Foster Care

Targeted Recruitment

Targeted Recruitment ► Goal: Increase placement stability for children in care

Inputs	Outputs	Outcome Linkages	Short-term Outcomes	Intermediate/ System Outcomes
Children in need of placements Staff increases Workers trained Contracted providers Geographic Information Systems Community partnerships	Number of resource families who inquire Number of foster homes opened Number of adoptive families Number of children placed in foster and adoptive homes Number of children placed in relative and kinship care Number of community partners engaged in recruitment activities	Targeted Recruitment ensures that appropriate placements are recruited and retained which increases the chances of children being placed in homes that meet their needs and thus to fewer placement disruptions	Increased number of children placed in appropriate homes • Number of recruited foster and adoptive families with preferences that match the children in foster care • Number of resource families who have received training that matches the needs of the child • Number of foster and adoptive families recruited in neighborhoods from which children were removed. • Number of children placed in no more than one home within the first three months of entry • Reduction in the number of moves requested by foster parents	Children in care experience greater placement stability • Increase in the number of children with two or fewer placements in one year Reduce the number of night spent in congregate care

Table 4. Targeted Recruitment GOAL: Increase Stability for Children in Care

Permanency Roundtables

Permanency Roundtables ► Goal: Expedite permanency for children in care

Inputs	Outputs	Outcome Linkages	Short-term Outcomes	Intermediate/ System Outcomes
Children in foster care for 18 months or longer Evidence-based practice Worker training CHRIS enhancements	Number of PRTs that occur with children in care for 18 months or longer Number of PRTs that end with a Permanency Action Plan	Permanency Roundtables assess the barriers to permanency and focus staff on overcoming those barriers, leading to children achieving permanency more quickly.	Family functioning is improved when goal is reunification • Number/ percent of children reunified within six and 12 months of the initial PRT Increase in children discharged to permanency • Number/percent of children discharged to a permanent home within six and 12 months of the initial PRT	Increase in children who achieve permanency in a timely manner • Reduction in the number/ percent of children discharged to IL or aging out of care • Reduction in the average length of time children remain in care

Table 5. Permanency Roundtables GOAL: Expedite Permanency for Children in Care

CANS/FAST

CANS/FAST ► Goal: Reduce the number of children entering foster care

Inputs	Outputs	Outcome Linkages	Short-term Outcomes	Intermediate/ System Outcomes
Families in in-home cases Staff increases Evidence-based tool Workers trained Supervisory oversight CHRIS enhancements	Number of families assessed Number of children in assessed families Number of families receiving services appropriate to needs	CANS results allow caseworkers to determine the most pressing needs of the family, resulting in services to meet those needs being delivered, which will better enable families to care for their children, thus leading to fewer children entering the foster care system	Fewer children enter the foster care system • Number/ percent of families with no child removed within 90 days of FAST assessment • Number/ percent of children not removed within 90 days of FAST assessment	Reduction in the proportion of the State's children in foster care • Decrease in the number/percent of children who are discharged from care within 90 days of entry • Decrease in the number/percent of children in foster care six and 12 months after each updated CANS/FAST

Table 6. CANS/FAST GOAL: Reduce Number of Children Entering Foster Care

CANS/FAST ► Goal: Increase placement stability for children in care

Inputs	Outputs	Outcome Linkages	Short-term Outcomes	Intermediate/ System Outcomes
Children in foster care Evidence-based tool Staff increases Worker training Supervisory oversight CHRIS enhancements	Number of families assessed Number of children in assessed families Number of families receiving services appropriate to needs	CANS assesses the highest priority needs of the children which leads to better matching of children to homes that meet their needs, leading to fewer placement disruptions	Increased number of children placed in appropriate homes • Number/ percent of children in homes where resource family preferences match child characteristics • Number/ percent of children placed in no more than one home within the first 90 days of entry	Children in care experience greater placement stability • Increase in the number/ percent of children with two or fewer placement settings in one year

Table 7. CANS/FAST GOAL: Increase Placement Stability for Children in Care

CANS/FAST ► Goal: Expedite permanency for children in care

Inputs	Outputs	Outcome Linkages	Short-term Outcomes	Intermediate/ System Outcomes
Children in foster care Evidence-based tool Staff increases Worker training Supervisory oversight CHRIS enhancements	Number of families assessed Number of children in assessed families Number of families receiving services appropriate to needs	CANS identifies the highest priority needs of youth and families which allows caseworkers to plan and deliver services to meet those needs, which will better enable families to care for their children, thus leading to more children achieving permanency through reunification	Family functioning is improved • Number/ percent of cases with lower scores on subsequent CANS compared to the initial CANS • Number/ percent of children who are reunified after six and 12 months in care	Increase in children who achieve permanency in a timely manner • Number/ percent of children reunified within one year • Number/ percent of children adopted or achieving guardianship within two years

Table 8. CANS/FAST GOAL: Expedite Permanency for Children in Care

Data Sources and Data Collection Methods

Process Evaluation

Six data sources were used to inform the process evaluation: *case reviews*, *extracts of CHRIS data*, *interviews*, *client surveys*, *document review of materials* such as training curricula and policy memos, and *focus groups with clients* of DCFS. The following table shows which data sources and collection methods were used for each initiative under the Waiver.

Initiative	Case Reviews	CHRIS Extract	Interviews	Family/ Caregiver Surveys	Document Review	Focus Groups
CANS/FAST	✓	✓	✓		✓	
Differential Response	✓	✓	✓	✓	✓	
Permanency Roundtables	✓	✓	✓		✓	
Team Decision-Making	✓	✓	✓	✓	✓	
Nurturing the Families of Arkansas	✓	✓	✓	✓	✓	
Targeted Recruitment	✓	✓	✓	✓	✓	✓

Table 9. Data Sources for Process Evaluation

Case Reviews

Structured case reviews were designed to capture qualitative and semi-quantitative information from electronic case records that were otherwise not available via a quantitative download of CHRIS data. A case review instrument was used to collect data from comparison and experimental sample cases from specified time frames, typically 50 per six-month cohort. Data were entered into an electronic case review tool, with data from CHRIS extracts pre-populated to help inform the analyses.

Case reviews cover not only process questions but also some outcome questions. Most questions in the case review instrument were fixed, objective questions, and some questions required judgment on the part of the reviewer. For these questions, reviewers were trained and given criteria and guidance to make those judgments. Additionally, inter-rater reliability was assessed intermittently throughout the case review period to ensure that reviewers were consistent in their rating.

CHRIS Extract

Extracts of quantitative case data from CHRIS were used to pre-populate case reviews with objective data. Examples of CHRIS data used to supplement case reviews include family and child characteristics; case outcomes, *e.g.,* date of reunification or subsequent

removal; practices completed, *e.g.,* date of protection plan; and other important dates relevant to the case.

Focus Groups

In order to have an understanding of resource families' perspectives, HZA conducted focus groups with foster and adoptive parents who were involved with the child welfare system. During the focus groups, six topics were addressed: the process of gaining approval to foster or adopt, the training for resource families, the availability and quality of supports that are provided for resource families, whether there is a lack of certain types of supports for resource families, challenges for resource families, and systemic changes that resource families believe would improve resource family recruitment and retention. Due to the limited response rate and attendance of focus groups, beginning in 2017, HZA substituted focus groups with interviews with families, with the approval of DCFS.

Interviews

On an annual basis throughout the evaluation, semi-structured interviews (fixed questions with open-ended responses) were conducted with staff at all levels of DCFS (including Central Office) who were involved with the implementation and execution of the Waiver initiatives. For some initiatives, community partners, such as social service organizations or contracted providers, were also interviewed. Interviews were primarily conducted in-person and conducted over the phone when in-person contact was not possible or feasible. Interview protocols were specific to each initiative. Interviews took place throughout the State in each Service Area, and the number of interviews varied each year, ranging between 75 and 100.

As noted above, focus groups with resource families did not create a large enough sample and were typically dominated by one or two families who were very upset. To achieve a larger, less biased sample, interviews were conducted in person in 2017 with interviewees receiving a $25 gift card to Walmart. Interviews generated a higher success rate, but due to the busy nature of foster families who were typically working or unavailable due to a sudden placement, phone interviews were performed in 2018 and met with a larger number of responses.

Family/Caregiver Surveys

Client input, gathered through surveys, was used to inform the process evaluation for four of the six initiatives. Surveys were administered after the case had closed or the intervention had been completed. Consisting of a combination of Likert scales and open-ended questions, the surveys assessed the degree to which families were satisfied with the service, the extent to which (from the family's perspective) the intervention was delivered with fidelity, the experience the family had with the service, and whether or not the desired outcome had been achieved.

For the DR and ARCCC initiatives, HZA initially mailed surveys to the parents or caregivers who received those interventions, providing them with a self-addressed postage-paid envelop to return the completed survey. Due to limited response rates, DR workers started giving the surveys to participants at the time of the last visit by the worker.

ARCCC surveys were emailed to parents the month after their approval. For NFA and TDM, HZA worked with MidSOUTH and DCFS staff to administer the survey upon completion of the program or meeting, respectively. MidSOUTH, DCFS staff or families mailed the completed survey back to HZA.

Document Review

DCFS offices at the State, Service Area and county levels were asked to submit documents that would illustrate their work on the Waiver. This includes information regarding policy updates, performance-based contracts, and staff qualifications and trainings.

Outcome Evaluation

Data for the outcome evaluation include both CHRIS and case record reviews. CHRIS extracts were generated semi-annually and include information around repeat maltreatment, removals from the home, demographic information, and other initiative specific information (*e.g.,* DR allegations). In addition to CHRIS extracts, case record reviews also contain quantitative data which were used in the outcome evaluation. A description of the case record review methodology is found above.

Cost Evaluation

Three data sources are available within DCFS to examine the costs associated with the Waiver programs: maintenance payments for children placed in out-of-home care and contracted provider costs for delivery of ancillary services to both children in foster care and those who remain in their homes. The third data source, administrative cost data, which are calculated by applying results from the quarterly Random Moment Time Surveys (RMTS), is not included in the cost evaluation. Arkansas's RMTS captures the percentage of time staff are involved in case management activities for Differential Response, Team Decision-Making and Permanency Round Tables. However, the percentages are so small that they have had very little, if any, fiscal impact on the Waiver program. As a result, the cost evaluation is limited to exploring costs for out-of-home care and ancillary services.

Data Analysis Plan

Process Evaluation

Three types of analyses were used for the process evaluation: *content analysis*, *descriptive statistics*, and *pre-post comparisons*. Conventional content analysis was used to analyze answers to the fixed, open-ended questions in interviews, focus groups, and the family/caregiver surveys. Results from the analysis were used to report on themes that emerge as well as the prevalence and frequency with which responses were reported by key stakeholders. Content analysis was also used to assess relevant project documents such as policy memos, training curricula and performance-based contracts. In the few places where narratives were called for in the case reviews, content analysis was used to identify common themes.

Most of the statistical information required for the process evaluation related to project outputs and consisted of simple frequencies. For semi-quantitative case review data (*e.g.,* number of DRs initiating on time), percentages were calculated from sub-samples, typically 50 families/children per six-month cohort, and projected in terms of the larger intervention population. For those items which were available from coded fields in CHRIS, counts and percentages of clients or case statuses were generally applied.

Analyzing how initiatives evolved over time used information from all process evaluation data sources to measure the extent to which inputs, interventions, and outputs changed. For example, results derived from baseline interviews were compared to those results derived from interviews conducted in later years of the project.

Outcome Evaluation

The general method of analysis for determining the success of the Waiver initiatives on outcomes of interest was prospective cohort analysis. Each case is measured from a defined starting point that is relevant to the initiative being analyzed, for example, referral of a case to DR or a protection plan being put into place. From this point in time, prospective data were analyzed to determine whether the outcome occurred within specified time frames, such as removal of a child from a home within 90 days or permanency achieved within twelve months. The statistical test used to determine whether there are statistically significant differences between the experimental and control groups are Welch's t-tests for continuous outcomes (*e.g.*, average time to DR case closure) and chi-squared tests for categorical outcomes (*e.g.*, youth removed 90 days after a TDM meeting).

Cost Evaluation

Average Cost per Child/Family

Maintenance Costs

While one goal of Arkansas's Title IV-E Waiver is to avoid removing children from their homes, when it is necessary to place them into substitute care it is hoped that the Waiver initiatives will either reduce the length of time children are in out-of-home placement and/or enable them to avoid placement in higher levels of care, or at least shorten the time they are out of the home. All of the Waiver initiatives are expected to play a role in achieving these goals and therefore reduce the overall costs of the child welfare system.

Comparisons are made for each initiative for costs incurred by children and families in the treatment groups, as well as the comparison groups. Foster home rates, as found in the Foster Home Handbook at the start of the evaluation, which take into account the age of the child at placement, were applied (roughly $15 per night). The child's age at the time of the DR Referral, TDM meeting date, NFA graduation date, date of placement into the ARCCC home, or initial CANS/FAST date (*i.e.*, trigger dates) are used in the calculation of costs for room and board. Congregate care rates were found using the median rate ($108.58 per night) among residential facility providers. The same rates are used consistently across all cohort periods and are not adjusted based on any rate increases

in order to measure costs consistently for each family and child. The number of nights in care are taken from the trigger dates, as noted above, and followed forward for one year following that date.

Service Costs

Each initiative is designed to identify the appropriate service(s) for each child in order to maintain his or her well-being whether the child is in the home or in substitute care. Services include assessments, case management (*e.g.*, home studies), counseling, medical, parenting, travel, and other maintenance (*e.g.*, attorney time, intensive family services).

Limitations

From a logistics perspective, a major limitation of the evaluation plan is the timing of when several of the interventions were implemented along with the timing of when initiative-specific data and information became available in CHRIS. To answer process evaluation questions regarding fidelity, implementation, and standards of practice, it was anticipated that documentation specific to each initiative's model would be input into CHRIS and used for analysis, both by way of CHRIS extraction and case reviews.

However, enhancements to CHRIS that would facilitate such documentation occurred later than anticipated, resulting in an initial lack of available data for cases that should have been included in early experimental cohorts, and a backlog of cases that required retroactive data entry. For example, the CANS/FAST screen in CHRIS was not available until that initiative was well underway, and DCFS staff had to retroactively input assessment information into CHRIS. Additionally, enhancements were not always developed or executed as anticipated, resulting in information that was slightly different than what was needed to answer specific evaluation questions. Finally, a lack of messaging regarding documentation and limited staff understanding of Waiver initiatives resulted in a lack of documentation across all initiatives, regardless of whether or not it was possible to input information into CHRIS. This limitation extends to the issue of relying on inconsistent narratives in case notes to inform process evaluation. From a methodological perspective, the reliance on CHRIS data to measure outcomes presents a limitation. As such, only information or indicators that exist in CHRIS can be used as a measured outcome, which limits the way in which the impact of initiatives was evaluated.

Some data sources originally included in the evaluation plan are no longer applicable to some initiatives. For example, case reviews were originally thought to be a valuable data source for the process evaluation of the ARCCC initiative. However, in the early months of implementation, the nature of the project evolved, and as such the initiative came to be known less as a targeted intervention or service and more of an environmental shift across the system.

There were also some limitations regarding surveys which were administered to gain the perspective of parents/caregivers. Response rates were lower than expected, with a rate as low as five percent for one initiative. To improve the rate of response, a different

strategy was employed in later stages of the evaluation to increase response rates. For example, instead of mailing the survey to parents/caregivers, DCFS and MidSOUTH handed the respective survey to participants, encouraging them to provide their feedback on their satisfaction with an initiative and how it could be improved. In both aforementioned instances, the survey response rates increased upon methodology change; however, the sample returned was likely positively biased since workers may have not chosen to hand surveys to those where the intervention was not successful.

Evaluation Time Frame

Table 10 describes the number of measurable six-month cohorts for each initiative in addition to the comparison group pool time frame and the analysis time frame. The comparison group pools typically consisted of cases and clients from one year prior to an initiative's implementation who likely would have received the intervention had it been available. From these pools, a comparison group was selected for each cohort of every initiative (with the exception of PRT) using the Propensity Score Matching (PSM) technique that is described in detail in each sub-section. The sampling plans for interviews, surveys, case record reviews, and CHRIS extracts can be found above.

Initiative	Number of Six-Month Cohorts	Comparison Group Time Frame	Analysis Time Frame
CANS/FAST	7	February 2014 – January 2015	February 2015 – July 2018
DR	10	August 2012 – July 2013	August 2013 – July 2018
PRT	6	August 2012 – July 2013	August 2013 – July 2016
TDM	8	September 2012 – August 2013	September 2014 – July 2018
NFA	7	March 2013 – February 2015	March 2015 – July 2018
ARCCC	7	August 2013 – January 2015	February 2015 – July 2018

Table 10. Evaluation Time Frames

Differential Response

Differential Response, implemented statewide in August 2013, was one of the first initiatives rolled out under the IV-E Waiver. The purpose of the initiative is to quickly connect families involved in low-risk child maltreatment allegations with community-based services in lieu of conducting investigations. DR is founded on the assumption that maltreatment reports vary in severity and that child welfare systems should respond with appropriate intensity. Reports with high-risk child maltreatment allegations are referred for the traditional investigation approach, which involves the gathering of forensic evidence to determine the existence of child abuse and/or neglect. In contrast, reports with low-risk allegations are referred for DR.

DR is designed to engage families in a non-threatening and non-accusatory manner in order to connect them to formal and informal community supports and services. By connecting families with useful services (*e.g.*, food banks, clothing, transportation), DR aims to safely reduce the number of children entering the foster care system, decrease future involvement with DCFS, and return youth to their homes quickly in the event a child is removed. According to Arkansas's child welfare policy, each family referred to DR is to receive an assessment which is designed to address the child's safety, the family's strengths, and any underlying needs or additional child maltreatment concerns not identified in the original report to the Abuse Hotline. The intent of DR is to engage the family in a conversation to learn about their strengths and needs as well as educate them on community services and how those services may provide support. This may include conversations about external supports and assistance in identifying the resources available within the family's own support system.

Process Study

Sample

To gain the perspective of the agency, staff from HZA spoke to 15 to 30 DCFS staff annually, inclusive of area directors, DR supervisors, and DR specialists about the program. Initial interviews were used to determine the readiness to implement DR while subsequent interviews were used to determine successes and challenges of process-related practices. Interviews were conducted with staff from all ten service areas annually.

Additionally, 50 to 60 case record reviews were conducted for nearly every six-month cohort of the DR initiative (Table 11); case record reviews were not completed for DR cases that opened during the last six months of the initiative. The reviews were completed using a structured instrument to collect data on both family well-being and fidelity of the DR process. The well-being questions focused on the family's service needs, services received, and the progress made by the family. The fidelity questions addressed the timeliness of key processes, *e.g.*, time from intake to case assignment and time to initial face-to-face contact with the family.

Surveys were administered to families soon after the DR cases closed to gain the perspective of the families on the services they received. These surveys were initially

mailed to families with pre-addressed pre-stamped envelopes within one month of DR case closure. To help increase the rate of response, starting in February 2017, the same survey and return envelope was handed to the family, in person, by the DR worker at the time of DR closure. In the 18 months since HZA made that change, 104 surveys were returned, compared to only 50 in the previous 18 months (Table 11).

Cohort	Survey Responses	Case Record Reviews
1. August 2013 – January 2014	0	63
2. February 2014 – July 2014	123	53
3. August 2014 – January 2015	24	63
4. February 2015 – July 2015	16	53
5. August 2015 – January 2016	0	50
6. February 2016 – July 2016	21	84
7. August 2016 – January 2017	13	59
8. February 2017 – July 2017	29	50
9. August 2017 – January 2018	59	50
10. February 2018 – July 2018	16	0
Total	**301**	**525**

Table 11. Process Evaluation Sampling

Results

Demographics

Table 12 shows the number of DR referrals received during each six-month cohort and the proportion of those referrals across the ten Service Areas. In Area 1, there was a noticeable increase in the proportion of DR referrals received between Cohort 5 (August 2015 – January 2016) and Cohort 6 (February 2016 – July 2016).

The count of youth involved with the DR referrals is also provided in Table 12, along with a description, displayed in percentages, of the demographic characteristics of those youth. (For cohort date ranges, see Table 11). Percentages for each demographic stay relatively consistent across cohorts. Roughly 75 percent of the children referred for DR are white and between the ages of five and fourteen.

Demographic	Tx 1	Tx 2	Tx 3	Tx 4	Tx 5	Tx 6	Tx 7	Tx 8	Tx 9	Tx 10
Number of Referrals	1884	1860	1711	1744	1766	2286	1945	2676	2750	2909
Number of Youth	3017	2938	2766	2697	2688	3300	2918	3775	3900	3986
Area										
Area 1	16%	17%	14%	18%	12%	25%	16%	22%	21%	22%
Area 2	10%	10%	13%	10%	11%	9%	10%	8%	8%	9%
Area 3	12%	13%	11%	11%	13%	9%	12%	10%	9%	10%
Area 4	6%	6%	5%	5%	7%	5%	6%	5%	7%	5%
Area 5	12%	11%	14%	10%	11%	11%	12%	9%	8%	8%
Area 6	10%	10%	8%	10%	10%	9%	12%	16%	16%	15%
Area 7	7%	7%	7%	7%	6%	7%	7%	6%	6%	6%
Area 8	12%	13%	13%	14%	16%	13%	13%	11%	13%	11%
Area 9	11%	9%	10%	11%	10%	9%	10%	9%	9%	10%
Area 10	5%	4%	4%	4%	5%	3%	3%	3%	2%	3%
Gender										
Male	51%	49%	46%	49%	52%	49%	49%	51%	48%	48%
Female	49%	51%	53%	51%	48%	51%	51%	49%	52%	51%
Race/Ethnicity										
Black	17%	17%	13%	16%	19%	14%	17%	17%	17%	17%
White	75%	74%	78%	75%	72%	75%	73%	72%	72%	72%
Other	6%	7%	7%	7%	8%	9%	8%	9%	8%	8%
Hispanic (Ethnicity)	5%	6%	5%	6%	6%	6%	6%	6%	7%	8%
Age										
Age 0–4	10%	9%	11%	9%	9%	7%	8%	8%	8%	8%
Age 5–9	40%	42%	41%	42%	41%	42%	39%	40%	39%	41%
Age 10–14	33%	34%	34%	33%	33%	33%	34%	34%	34%	34%
Age 15–17	16%	14%	14%	15%	16%	17%	18%	17%	18%	17%
Age 18+	0%	0%	0%	1%	1%	0%	0%	0%	0%	0%

Table 12. Demographic Information for DR Referrals

Organizational Readiness

Prior to implementation of DR, Area Directors and County Supervisors completed a readiness questionnaire around their respective Areas' and counties' abilities to implement the initiative. Most Area Directors examined the qualifications of their staff to identify those who would be good candidates to work with DR families and assess which counties within their respective Service Areas would be a good fit to first implement DR. During the first years of DR, most (if not all) DR workers also had investigation cases on their workload. Because DR was piloted in 32 counties prior to the full statewide rollout under the Waiver, policy and tools for DR implementation were previously created and in place at the start of the Waiver.

Staff Training

Initial training for DR was a weeklong session which provided an overview of the purpose, policies, and process for conducting a DR assessment. The training was conducted by the DR coordinator. Staff reported that the training focused on how to implement a DR assessment, providing staff with scenarios that would require DR, and taught staff how to engage with the family. Supervisors provided informal follow-up training and ongoing support to their staff.

Overall, those interviewed had mixed reactions to the trainings. Some said the formal training was too long, yet others reported that it was too short and that too much information was given in a short period of time, which was overwhelming. Since the initial training, staff have reported a need for more frequent training, especially since turnover is high and some workers are receiving "on the job" training. DR staff who disliked the formal training reported it did not adequately prepare them for the timelines and data entry requirements within CHRIS for DR cases.

DR Referrals

Six criteria must be present for a report of alleged maltreatment to be assigned for a DR assessment: a) correct identifying information must exist; b) the alleged perpetrators must be the parent/caregiver; c) the family must not have a pending or open protective or supportive services case; d) the victim or household members must not be in the custody of DCFS; e) protective custody is not required; and f) the reported allegation must be within a specified range of maltreatment types, usually associated with neglect. Results from the case record reviews find that 85 percent of the referrals to DR met all criteria.

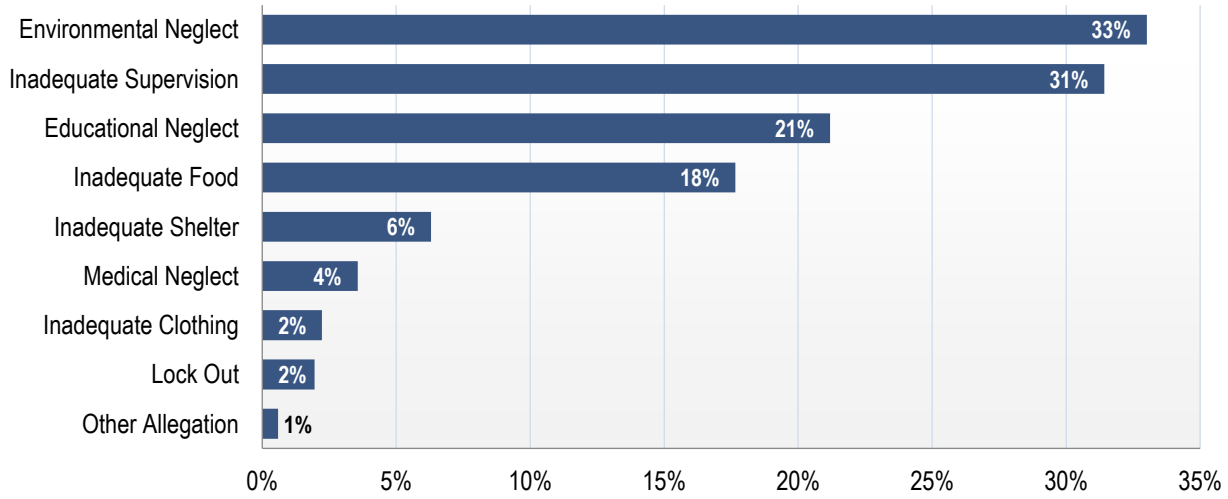
Criteria	Percentage
Correct Identifying Information	94
Alleged Perpetrator is Parent/Caregiver	98
No Pending/Open Child Protective or Supportive Service Case	94
Victim Not in DCFS Custody	100
Protective Custody Not Required	89
Meets Maltreatment Allegation Type	100
Meets All Criteria	85

Table 13. Percentage of DR Case Record Reviews Meeting Criteria

In January 2015, five new allegations were added to the criteria for Differential Response under certain conditions, namely human bites, sprains/dislocations, striking a child age seven or older on the face, striking a child with a closed fist, and throwing a child, all of which needed to have occurred over one year prior to the reporting date. If the caller to the hotline can verify an injury either through physical signs (*e.g.*, scarring), medical information, dated photographs, etc., reports will still be assigned to the investigative pathway.

Figure 1 shows the percentage of all DR cases opened in CHRIS with a given allegation. Overall, environmental neglect is the most common allegation for which families are referred, followed by cases with an allegation of inadequate supervision and/or educational neglect. The types of allegations and the proportion to which they are reported have remained relatively consistent across the lifetime of the initiative, with the exception of education neglect. The proportion of reports with an allegation of educational neglect has increased from less than 10 percent of referrals in the first Cohort to more than 30 percent in the most recent Cohort. This rise is likely due to a large push by the school systems for teachers to report truant youth to DCFS, as noted by DCFS staff in the waiver core team meetings. The category "Other Allegation" includes unverified incidents of physical abuse, such as human bites or sprains/dislocations that occurred more than a year prior to the report.

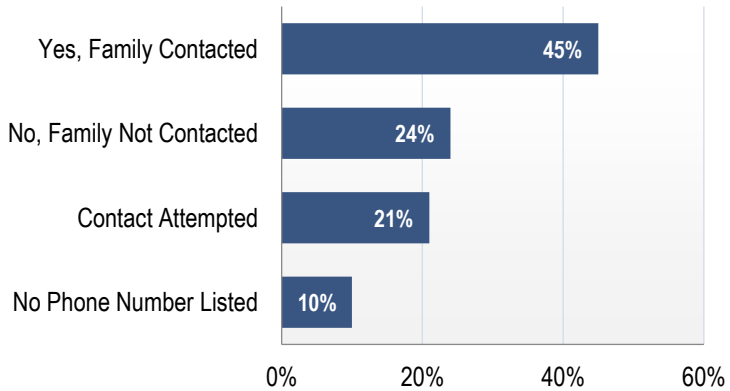
Figure 1. Percentage of Cases with Allegation



Implementation

Once the referral is assigned to the DR specialist, contact with the family should be made within 24 hours to schedule an initial meeting. Figure 2 shows that contact within 24 hours of case assignment was made in 45 percent of the reviewed referrals. The caseworker was found to have attempted to make contact for another 21 percent of the referrals, bringing the overall compliance rate up to 66 percent.

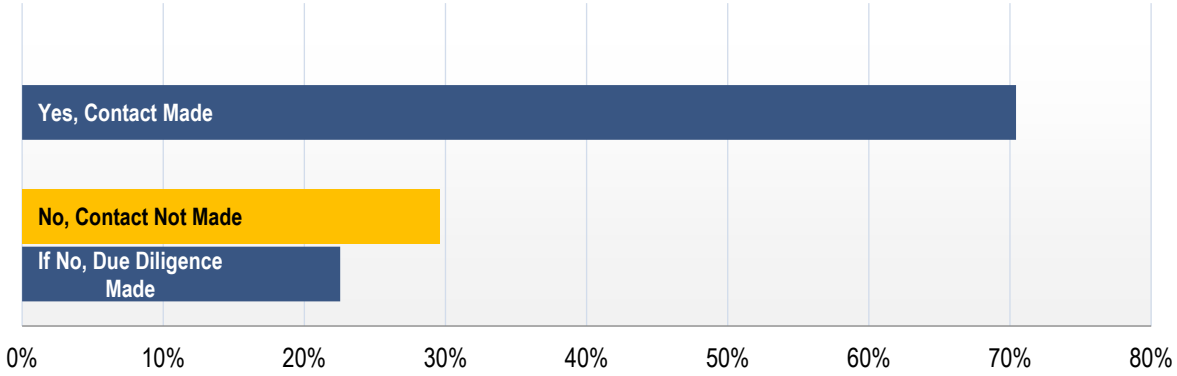
Figure 2. Contact the Family by Phone within 24 Hours of Case Assignment



The original DR policy mandated the DR Specialist to meet face-to-face with all household members within 72 hours of receipt of the Child Abuse Hotline referral. Given that homes often have multiple household members with varying schedules, this requirement was found to be a challenge and negatively impacted DR initiation rates. A policy revision, effective May 2014, allowed the DR Specialist to initiate DR by observing and/or speaking with the victim child(ren) and at least one parent/caretaker within 72 hours of receipt of the Child Abuse Hotline referral (the DR Specialist is still required to meet face-to-face with all other household members within five days of the hotline referral).

Overall, DR Specialists met face-to-face with at least one/parent caregiver and the child victim(s) within 72 hours in 70 percent of the reviewed cases. Of the remainder where face-to-face contact was not made within 72 hours, case workers documented due diligence in attempting to meet the family in three-quarters of those cases. Caseworkers failed to meet with families within 72 hours or exhibit due diligence for seven percent of the DR cases overall (Figure 3).

Figure 3. Face-to-Face Contact within 72 hours of Initial Hotline Report



Family-Caseworker Interaction

The survey which was administered to DR families included a series of questions about the implementation and fidelity of the DR service, with results provided in Figure 4.[2] Nearly all families reported the worker explained the purpose of the contact and nearly 90 percent reported the worker visited with all members of the family when they visited the home. The lowest response from families (72 percent) was around worker follow-up on the goals created at the beginning of DR.

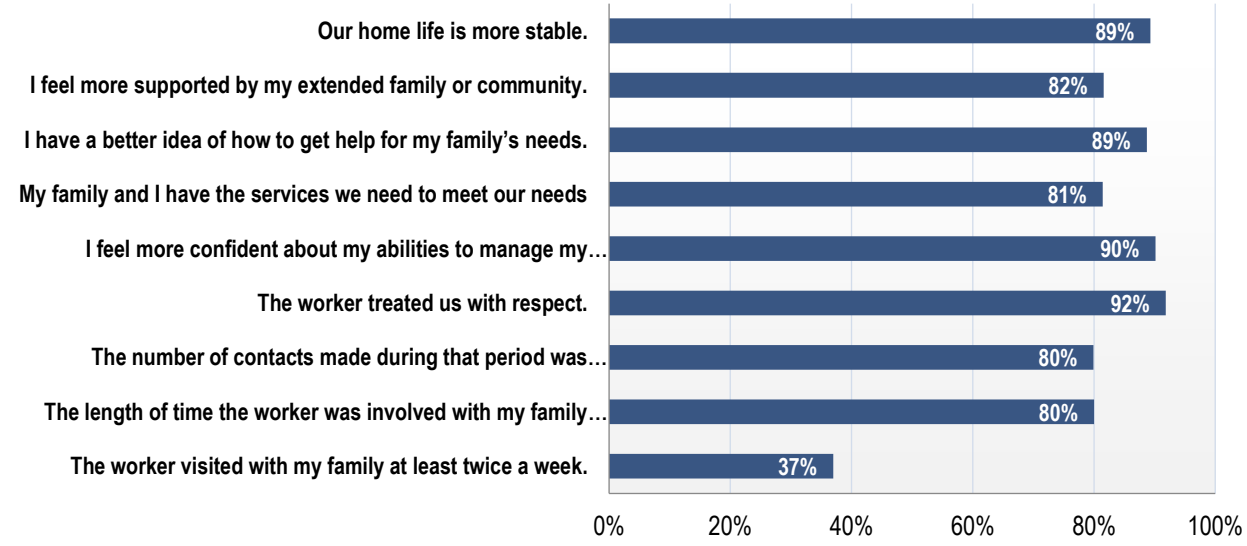
[2] Families did not have to answer all the questions contained within the survey. The percentages are reflective of those for which an answer was received to the question.

Figure 4. Percentage of Families Responding "Yes" to the Following Questions

Family Engagement/Satisfaction

The family survey was used to gather from the families' perspectives the benefits of DR. Families were asked the extent to which they agreed or disagreed with particular statements on a four-point Likert scale, ranging from "Strongly Agree" to "Strongly Disagree," with results provided in Figure 5. Families responding to the survey largely reported they received the services they need, they feel more confident in managing their needs, and their home life is more stable. While only 37 percent of the families reported the DR worker met with the family twice a week, 80 percent of the families indicated the amount of time the worker spent with the family was enough to meet their needs.

Figure 5. Percentage of Families Agreeing with the Following Statements



Discussion

Successes and Strengths

Empowering Families

Families receiving DR assessments appreciated the voluntary and non-threatening nature of the program and workers are excited about the different, family-centered approach to working with DCFS-involved families. Due to the non-adversarial and engaging approach that the DR Specialists take, families are more accepting of the intervention and services. The program was found to be able to connect families to the services they need. Family survey data show that 90 percent of participating families were more confident in managing their families' needs following DR, and 89 percent agreed that they enjoy a more stable home life following DR.

Positive Perceptions of Arkansas DCFS

Interviews with agency staff overwhelmingly found that the non-threatening and voluntary nature of DR is casting a more positive light on DCFS. The non-accusatory tone of the program helps to build trust with families and consequently makes DCFS more approachable. One Area Director stated that "getting out there and meeting with the family in a non-adversarial role makes them feel like we're there to support and help them as opposed to us pointing fingers." One DR specialist viewed his/herself as an ambassador, enabling families not to associate the agency with only negative experiences.

Challenges and Limitations

Engaging Community Resources

A common theme across all stakeholders during interviews was the lack of community support in terms of program acceptance and resource assistance. It was apparent that in some Service Areas, community stakeholders are resistant to the program because they do not understand the mission. A few times HZA heard that educational sessions or outreach information to community members would be helpful. DR specialists cited the scarcity of community resources for them to lean on.

Rural areas

Several challenges have presented themselves when implementing DR in rural areas.

- *Limited staff* – The smaller number of staff in rural areas made it difficult to have designated DR workers who specialize in the DR job responsibilities.
- *Large driving distances* – DR workers have difficulty in meeting families face-to-face promptly due to onerous travel times.
- *Limited community services* – Families often do not have adequate services available to them locally and must travel to urban areas to receive the services they need.

DR Worker Specialization

Although some new staff were hired, the implementation of DR has placed a burden on some smaller counties. In these counties, it is not possible to have staff who are dedicated to working solely with DR families.

When making the decision to place additional DR staff in particular counties a review of the number of referrals each county received per month was considered. Many areas that had specialized DR teams have found success and ownership of the program through this specialization. A consideration of geographical area was also brought in to the decision-making process when allocating additional staff. Area 1 received the most waiver positions (three), while Areas 3, 4, 5, 9, and 10 were all given one position each and Area 8 received two positions. The Areas are attempting to specialize the local DR Units and this was made possible through the dedicated positions.

Outcome Study

DR was implemented to reduce the length of time families engage with DCFS, helping them to quickly access the services and supports they need. The initiative was also designed to keep children safe, avoiding further involvement in the system, and provide the necessary services that if a child is removed from the home, to return them to their homes quickly.

Comparison/Cohorts

Six-month cohorts were used to measure outcomes of the DR initiative. Comparison cases for each cohort were selected from cases for which an investigation was closed between August 1, 2012 and July 31, 2013 and the allegation(s) satisfy the DR criteria. Propensity score matching was used to select cases from the comparison pool which resemble the characteristics of those in the treatment group. Propensity scores were determined using allegation type(s), service area,[3] county, number of male children in the case, number of female children in the case, the average age of the children in the case, and the race and ethnicity of the family. Propensity scores were matched using a nearest neighbor algorithm.

[3] In Cohorts 8 and 9, the characteristics of the treatment group changed significantly, necessitating a change in the criteria applied to select the comparison group. The service area, educational neglect, and inadequate supervision criteria were unable to be matched. These adjustments were driven by the changing characteristics of DR cases, not from the evaluators' decision.

Table 14 shows the statewide count of cases in the treatment and comparison groups for each cohort. Cohort 10 was not matched because not enough elapsed time to measure outcomes.

Cohort	Number of Treatment Cases	Number of Comparison Cases
1. August 2013 – January 2014	1884	1538
2. February 2014 – July 2014	1862	1719
3. August 2014 – January 2015	1713	1587
4. February 2015 – July 2015	1747	1651
5. August 2015 – January 2016	1770	1659
6. February 2016 – July 2016	2299	2157
7. August 2016 – January 2017	1956	1551
8. February 2017 – July 2017	2694	2522
9. August 2017 – January 2018	2770	2538
10. February 2018 – July 2018	2909	—

Table 14. Number of Cases in Treatment and Comparison Groups by Cohort

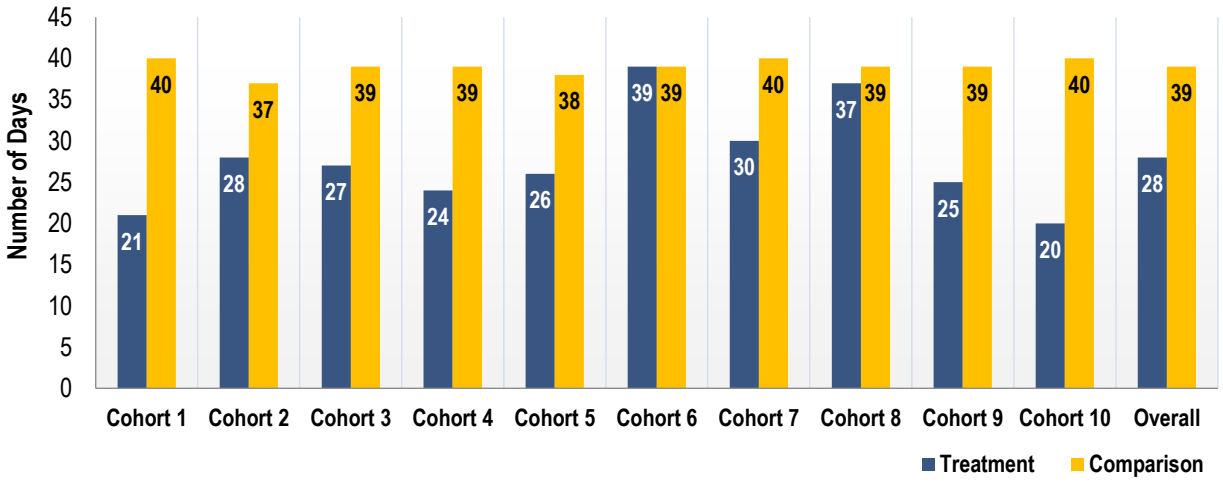
Results

Case Duration

DR was designed to expedite workers' engagement with families, provide frequent visitation and offer intensive yet short-term support. Figure 6 shows the average number of days DR and comparison group cases were opened. Overall, the average DR case was open for 28 days, 11 days fewer than the comparison group; this result is significant.

For the first two and a half years of implementation (Cohorts 1 through 5), DR case lengths averaged 25 days in duration. In Cohorts 6 and 8, the case length increased to nearly 40 days, which is likely due to the substantial increase in DR referrals during this time period and DR workers being overwhelmed with the significant increase. In the last year of implementation (Cohorts 9 and 10), case lengths decreased even with the large number of referrals, likely due to having experienced DR workers who are used to managing large caseloads.

Figure 6. Average Number of Days DR Case is Open



Subsequent Maltreatment Reports

The underlying goal of DR is twofold: first, reduce the percentage of cases which suffer from subsequent maltreatment and, second, reduce the number of children removed from their homes. Subsequent maltreatment is addressed in Table 15[4] which shows the percentage of cases in the treatment and comparison groups with subsequent involvement with DCFS within three, six and twelve months of the DR case closure. Highlighted cells are those with statistically significant differences between the treatment and comparison groups.

Overall, families receiving DR are significantly less likely to have a subsequent Child Protective Services (CPS) case open within three, six, and twelve months following the DR than comparison group families. Additionally, DR families are less likely to have a subsequent report of maltreatment, yet more likely to have a subsequent Supportive Services (SS) case open within the same three, six and twelve-month time frames than comparison group families. These trends are generally the same across all Cohorts.

[4] Cohort 10 is not included for the remainder of this section since not enough time has passed to measure outcomes.

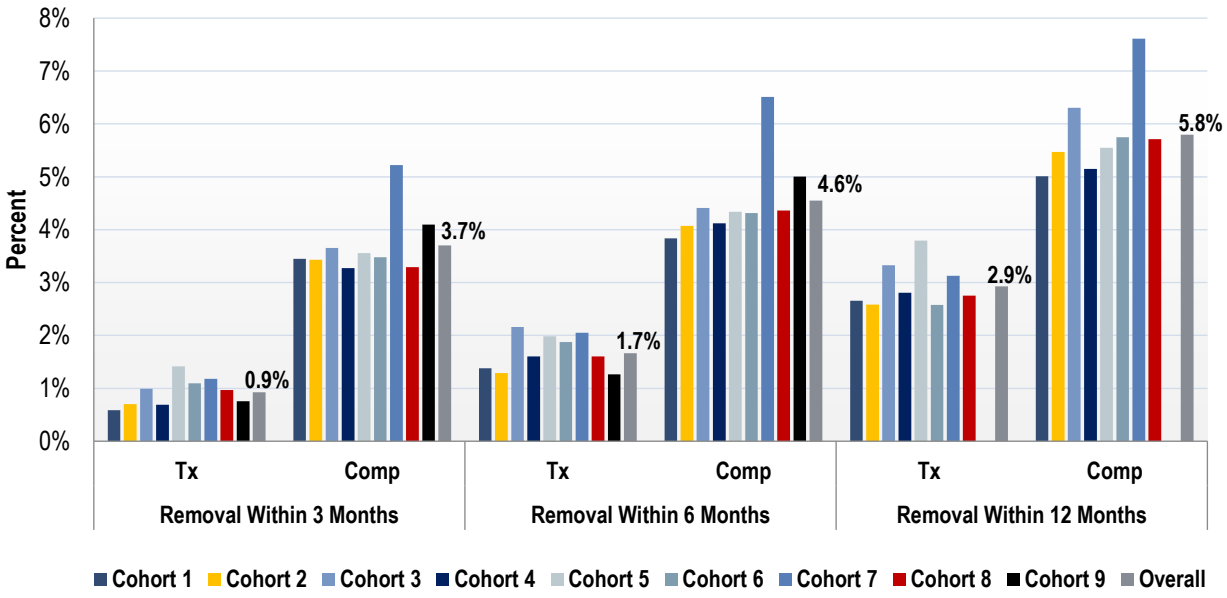
		Subsequent Maltreatment			Subsequent DR Referral			Subsequent CPS Case			Subsequent SS Case		
Cohort	Group	3 Mo	6 Mo	12 Mo	3 Mo	6 Mo	12 Mo	3 Mo	6 Mo	12 Mo	3 Mo	6 Mo	12 Mo
Cohort 1	Tx	1.4%	2.7%	4.5%	1.1%	2.4%	4.0%	1.8%	3.0%	4.7%	0.7%	0.8%	1.0%
	Comp	2.9%	4.2%	6.0%	—	—	—	12.9%	13.8%	15.2%	0.8%	0.8%	0.9%
Cohort 2	Tx	2.3%	3.7%	5.9%	1.4%	2.4%	5.2%	2.7%	4.2%	6.6%	0.9%	1.0%	1.1%
	Comp	2.4%	4.1%	6.6%	—	—	—	13.8%	15.0%	16.8%	0.6%	0.9%	1.0%
Cohort 3	Tx	2.9%	4.6%	7.2%	2.5%	4.3%	7.1%	2.3%	4.6%	6.6%	1.2%	1.3%	1.4%
	Comp	2.1%	3.9%	6.9%	—	—	—	13.2%	14.2%	16.4%	0.7%	0.9%	0.9%
Cohort 4	Tx	1.8%	3.7%	5.8%	3.0%	4.5%	6.5%	2.5%	4.6%	7.6%	1.0%	1.1%	1.3%
	Comp	2.7%	4.2%	6.4%	—	—	—	13.6%	14.8%	16.4%	0.3%	0.4%	0.5%
Cohort 5	Tx	2.4%	4.0%	6.4%	2.6%	4.6%	6.4%	2.5%	3.8%	6.2%	1.3%	1.4%	1.6%
	Comp	2.5%	4.2%	6.0%	—	—	—	14.6%	15.7%	17.2%	0.6%	0.8%	1.0%
Cohort 6	Tx	2.2%	3.4%	4.9%	2.2%	3.4%	6.3%	2.0%	3.1%	4.8%	0.2%	0.3%	0.4%
	Comp	3.0%	4.7%	7.1%	—	—	—	15.9%	17.0%	18.9%	0.3%	0.4%	0.5%
Cohort 7	Tx	2.6%	4.7%	7.1%	5.1%	7.9%	12.3%	2.8%	5.7%	8.0%	1.8%	1.9%	2.3%
	Comp	2.1%	3.9%	6.8%	—	—	—	17.7%	19.3%	21.5%	0.3%	0.5%	0.6%
Cohort 8	Tx	1.9%	3.6%	5.8%	2.8%	5.0%	8.4%	1.7%	3.1%	4.9%	0.8%	0.8%	1.2%
	Comp	3.0%	4.4%	6.9%	—	—	—	14.3%	15.5%	17.4%	0.4%	0.5%	0.6%
Cohort 9	Tx	1.9%	3.4%	—	3.6%	6.2%	—	2.0%	3.3%	—	0.6%	0.8%	—
	Comp	2.5%	4.2%	—	—	—	—	14.0%	15.0%	—	0.3%	0.4%	—
Overall	Tx	2.1%	3.7%	5.9%	2.7%	4.5%	6.9%	2.2%	3.8%	6.1%	0.9%	1.0%	1.2%
	Comp	2.6%	4.2%	6.6%	—	—	—	14.4%	15.6%	17.5%	0.5%	0.6%	0.7%

Table 15. Percentage of Cases with Subsequent DCFS Involvement Within 3, 6, and 12 Months of DR Closing Date

Child Removals

Figure 7 shows the extent to which children remain in their homes within three, six, and twelve months following the closing of the DR case. Children involved in a DR case are significantly less likely to be removed from the home compared to children in the comparison group across the duration of the Waiver and all cohorts. This is true across all cohorts and removal time frames.

Figure 7. Percent of Cases with at Least One Child Removed



Children Discharged from Care

If a child was removed from the home, it is hoped that the services and community support which are provided to the family as part of the DR case might allow for the child to be returned to the home sooner than what had transpired in the past. Table 16 shows both the percentage of children who entered foster care within one year after the DR case closed, and the percentage which reunified or were placed in relative custody within three, six, and twelve months of removal.

Overall, children are significantly less likely to be returned to their home if they were involved with DR compared to those in the comparison group at three, six, and twelve months after the removal. Less than half of the youth removed after a DR are returned home within twelve months of the removal. Because a lower percentage of youth who receive a DR are removed, those who are removed likely have more serious conditions that could affect reunification and are thus more likely to remain in foster care longer.

Cohort	Percent of Children Entering Care		Percentage of Children Removed from Home Who are Discharged from Care Within					
			3 Months		6 Months		12 Months	
	Tx	Comp	Tx	Comp	Tx	Comp	Tx	Comp
Cohort 1	2.5%	5.3%	24.3%	30.6%	33.8%	42.7%	51.4%	58.9%
Cohort 2	2.4%	5.2%	22.5%	32.4%	33.8%	46.0%	50.7%	59.7%
Cohort 3	3.1%	6.5%	24.7%	30.1%	35.3%	38.7%	55.3%	55.8%
Cohort 4	2.6%	5.2%	21.7%	28.8%	26.1%	41.7%	37.7%	60.6%
Cohort 5	3.3%	6.1%	13.5%	39.6%	21.3%	50.0%	32.6%	64.3%
Cohort 6	2.1%	5.5%	26.8%	34.5%	42.3%	52.0%	64.8%	64.9%
Cohort 7	3.0%	8.2%	18.4%	35.2%	32.2%	50.3%	—	—
Overall	2.7%	6.0%	21.4%	33.3%	31.8%	46.3%	48.3%	60.8%

Table 16. Percentage of Children Entering and Discharged from Foster Care

Discussion

DR is designed to engage families in a non-threatening and non-accusatory manner in order to connect them to formal and informal community supports and services. The purpose of the initiative is to quickly connect families involved in low-risk child maltreatment allegations with community-based services in lieu of conducting investigations.

DR has succeeded in reducing the amount of time that cases are open. DR cases are open an average of 28 days, significantly shorter than the average of 39 days for the comparison group. DR cases are less likely to have subsequent involvement than the comparison group at three, six, and twelve months following closure of the DR case; and are less likely to result in a removal compared to the comparison group. Despite these successes, children removed from the home after DR involvement are less likely to be returned to their home within twelve months as opposed to those in the comparison group.

Cost Study

Table 17 displays the cost of room and board payments for children who were removed from their homes and service payments for all case members for up to twelve-months following the DR closure date for the treatment group and investigation end date for the comparison group. In general, the average cost per family is cheaper by nearly $150 for DR families than comparison group families.

The majority of the cost savings comes from reducing the length of stay for children placed in substitute care. Treatment group youth spent roughly 2,000 fewer nights per year in

congregate care and 11,000 fewer nights per year in a family foster care setting than youth in the comparison group. Because the cost of congregate care ($108/night) is over seven times more than foster care costs ($15/night), reducing the number of nights youth spend in congregate care has more of an impact on the cost than reducing the length of stay in family foster homes.

Of those treatment group youth who were removed from their home, 71 percent were placed in a family foster care setting and 64 percent were placed in a congregate care setting compared to 82 and 65 percent[5], respectively, for comparison group youth. When the average length of stay per child is examined, the analysis shows the average length of stay per child in congregate care is 10 days less for the treatment group than the comparison group and 55 days less when placed in a family-like setting. The combined factors of having a lower proportion of youth placed in out-of-home care and shorter lengths of stay produce an annual savings for treatment group cases amounting to nearly $400,000 per year, or $1.54 million over the four years displayed in Table 17.

Cohort	Total Number of DR Referrals	Total Foster Care Costs	Total Congregate Care Costs	Total Service Costs	Average Cost per Referral
Treatment Group					
1	1884	$72,316.72	$477,969.16	$5,169.65	$294.83
2	1862	$74,968.57	$422,810.52	$4,832.88	$269.93
3	1713	$87,800.40	$653,434.44	$6,786.65	$436.67
4	1747	$75,240.24	$614,562.80	$4,248.67	$397.28
5	1770	$154,954.35	$589,480.82	$3,422.64	$422.52
6	2299	$78,759.89	$344,632.92	$4,077.50	$185.94
7	1956	$133,708.65	$636,061.64	$10,257.59	$398.79
8	2694	$164,421.67	$602,619.00	$6,339.74	$287.08
Total	**15925**	**$842,170.49**	**$4,341,571.30**	**$45,135.32**	**$328.34**
Comparison Group					
1	1538	$189,572.20	$592,629.64	$3,824.05	$511.07
2	1719	$170,562.30	$717,170.90	$5,027.77	$519.35
3	1587	$220,994.04	$723,468.54	$10,068.30	$601.47
4	1651	$191,165.00	$651,805.74	$7,817.08	$515.32
5	1659	$178,217.77	$675,259.02	$9,299.10	$520.06
6	2157	$202,895.11	$664,401.02	$10,266.32	$406.84
7	1551	$161,057.81	$479,706.44	$10,508.21	$419.90
8	2522	$180,318.75	$700,341.00	$16,750.17	$355.83
Total	**14384**	**$1,494,782.98**	**$5,204,782.30**	**$73,561.00**	**$470.88**

Table 17. Maintenance and Service Costs for DR

[5] Percentages total more than 100 percent since the same youth may be placed in both foster and congregate care settings.

Team Decision-Making

Team Decision-Making meetings are held within 48 hours of a protection plan being put into place or at the time a Garrett's Law case is reported. Family and extended family, friends, and informal supports are invited by the family to attend the TDM and brainstorm ways to keep the child(ren) safe. DCFS is involved mostly to ensure that the final plan, developed via the TDM participants, meets the Division's requirements for keeping the child safe. The rapid response and action plan are designed to safely reduce the number of children entering the foster care system and, in the event a child needs to be removed, return youth to their homes by following the action plan.

Process Study

The TDM process study has the aim of assessing the quality of implementation of the TDM process in Arkansas, as well as the implementation's fidelity to the TDM model as outlined by the Annie E. Casey Foundation (Casey). Key outputs include an analysis of the degree to which families and staff were satisfied with the TDM process, the number and types of service referrals arising from a TDM meeting, and extent to which the TDM meetings were held with fidelity to the model. Challenges as well as successes in implementing the model were also examined.

Sample

Case records for roughly 50 cases in each six-month cohort were randomly selected for whom a TDM meeting was held, stratified by the Service Areas involved in TDM such that each Area received the same number of cases to be reviewed.

Family surveys were administered to solicit family feedback on the process and to gauge family satisfaction. HZA worked with MidSOUTH and DCFS staff to administer the survey to families following completion of the meeting. Surveys were administered to all parents and caregivers completing a TDM at the end of the month following the TDM meeting. The number of surveys returned per cohort are listed in Table 18.

Cohort	Responses
September 2014 – August 2015	25
September 2015 – February 2016	199
March 2016 – August 2016	147
September 2016 – February 2017	216
March 2017 – August 2017	214
September 2017 – February 2018	311
March 2018 – July 2018	203
Total	1,315

Table 18. Number of Survey Responses

Interviews were also conducted to solicit staff feedback on the TDM process and implementation. HZA conducted approximately 15 to 30 interviews annually with

randomly selected DCFS staff, with one county randomly selected from each Service Area. The county selected in each Service Area changed each year.

Results

Initiative Rollout and Implementation

Initial implementation activities for Team Decision-Making took place in July and August 2013 and consisted of conducting research of other states' efforts to implement TDM. Ongoing consultation was received from the Annie E. Casey Foundation which later culminated in the submission of draft policies for TDM and procedures for review.

Casey strongly recommended that TDM facilitators be hired at a supervisory level. This created challenges for DCFS because the Division had a limited number of supervisory positions available. To solve this, the DCFS Personnel Unit created five Family Service Worker (FSW) Specialist (*i.e.*, TDM facilitator) roles which, while not supervisory, are nonetheless one grade higher than the FSW level. To ensure that sufficient and appropriate staff were able to be hired and properly trained, the implementation of TDM meetings was delayed until September 2014.

Arkansas launched TDM in Saline, Faulkner, and Conway counties, then expanded into Pulaski, Craighead, Lawrence, and Randolph counties in January of 2015. Initially, the number of TDM referrals were low due to a small number of cases having a protection plan put in place, since TDM meetings are designed to utilize the protection plan to best determine the service needs of the family. In response, DCFS expanded the implementation of TDM into nine new counties, including Garland, Sebastian, Greene, Crawford, Hot Springs, Miller, Pope, Union, and Columbia.

In addition to adding more implementation counties, the decision was made to add all Garrett's Law referrals as an additional trigger point. Garrett's Law cases are accepted for investigation when there is a presence of an illegal substance in a child or its mother at the time of birth resulting from the mother's knowing use of the substance. Arkansas policy requires a protective services case to be opened to establish a plan of safe care on all Garrett's Law investigations with a true but exempt finding. The TDM meeting was used to establish this plan of safe care.

Demographics

Table 19 shows the number of TDM meetings held between September 2014 and July 2018 and the proportion of the meetings held in each Service Area, broken down by six-month cohort. The number of youth involved with those meetings is also presented and their demographics, displayed as percentages. As noted in the section above, the addition of Garrett's Law as a qualifying criterion had a noticeable impact on TDM's from Cohort 2 (March 2015 – August 2015) to Cohort 3 (September 2015 – February 2016), which is when DCFS required a TDM meeting to be conducted in response to this referral. As such, it is not surprising that the percentage of children less than five years-old increased

beginning in Cohort 3. The percentage differences of TDMs by Service Area reflect the roll-out of the initiative from four-to-six service areas.

Demographic	Tx 1	Tx 2	Tx 3	Tx 4	Tx 5	Tx 6	Tx 7
Number of Referrals	32	205	297	337	294	332	353
Number of Youth	62	489	641	722	639	686	754
Garrett's Law							
Garrett's Law Involved	9%	28%	61%	71%	76%	72%	76%
Area							
Area 2	0%	17%	28%	23%	28%	18%	22%
Area 3	31%	29%	35%	42%	46%	43%	33%
Area 4	0%	10%	10%	12%	17%	17%	18%
Area 5	31%	27%	20%	20%	21%	11%	12%
Area 6	28%	16%	13%	21%	3%	19%	33%
Area 8	13%	21%	29%	24%	30%	27%	25%
Gender							
Male	40%	52%	53%	52%	52%	51%	52%
Female	60%	48%	47%	48%	48%	49%	48%
Race/Ethnicity							
Black	24%	20%	25%	25%	20%	25%	30%
White	69%	71%	65%	65%	71%	62%	62%
Other	6%	9%	10%	10%	8%	12%	7%
Hispanic (Ethnicity)	0%	1%	2%	4%	4%	7%	3%
Age							
Age 0–4	48%	43%	61%	63%	64%	63%	63%
Age 5–9	29%	28%	22%	20%	19%	19%	20%
Age 10–14	18%	18%	12%	11%	11%	13%	12%
Age 15–17	3%	9%	4%	4%	3%	4%	3%
Age 18+	0%	0%	0%	0%	0%	0%	0%

Table 19. Demographic Information for TDM

Training

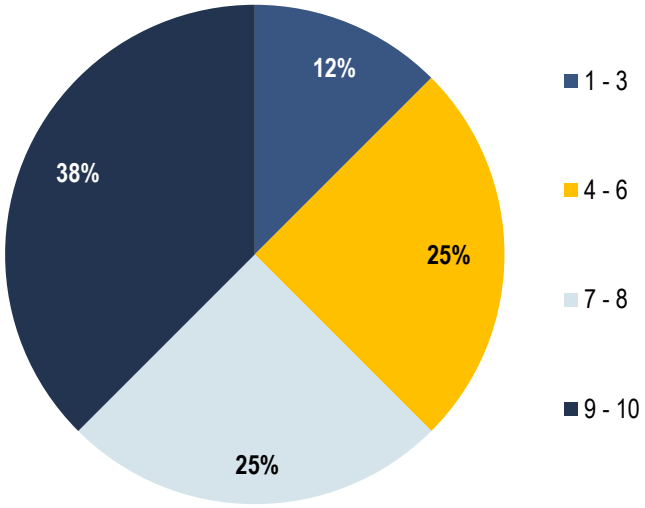
Casey conducted introductory site visits with the Team Decision-Making Workgroup in October 2013 and January 2014 which were used to provide an overview of TDM and involved discussions regarding developing a comprehensive approach to training, communication planning, and preparing for final readiness activities for the first phase TDM counties. DCFS has continued to receive technical assistance from Casey while planning for the sustainability of the facilitator training, stakeholder overview, and plan development for embedding the practice into the statewide system.

A facilitator training was conducted in August 2014 with FSW Specialists, Supervisors, Sponsors, and Co-leads, as well as three Bowen School of Law Mediators (back-up TDM

facilitators). This interactive training not only taught participants the philosophy and core components of TDM, but also addressed elements of facilitation and allowed participants time to practice newly learned facilitation skills and conduct mock TDM meetings.

Starting at the end of 2016, annual follow-up trainings were conducted; interviewed staff reported they were satisfied with the trainings they received. All but one of the staff members fulfilling a supervisory role (*e.g.*, area directors, county supervisors, and family service worker supervisors) reported that training for FSW Specialists was adequate in preparing them to implement the meetings. Mock TDMs are used as part of the training, which staff have spoken highly of; one Area Director stated, "Mock TDMs have been great for everyone to see the roles of each team member and [they get] them to identify what the role of each participant is."

Figure 8. On a Scale of One to Ten, How Family Service Workers Rated the Training



By February of 2018, nearly two-thirds (62 percent) of interviewees who had gone through the Team Decision Making training process rated the training as a seven or higher on a ten-point Likert scale, as shown in Figure 8. Staff reported the training helped them to define the worker's role in the meeting and logically explained the process of conducting a meeting. Those who reported a six or less described the training as being too long and "based on the best-case scenario" instead of providing more realistic scenarios of a TDM meeting.

Meeting Implementation

TDMs are supposed to occur within 48 hours of the development of the protection plan. Since September 2014, case record data reported 80 percent of the meetings satisfied the 48-hour criteria. By the end of the demonstration period, agency staff most commonly reported that family participation is one of the strengths of the TDM meetings. One family service worker reported that, "it provides a unique platform for the parent's voice to be heard." Additionally, interviewees report the meetings provide a chance for families to learn about the services they need to keep their children safely in the home, or if a removal is necessary, the steps the parents can take to reunify with their child.

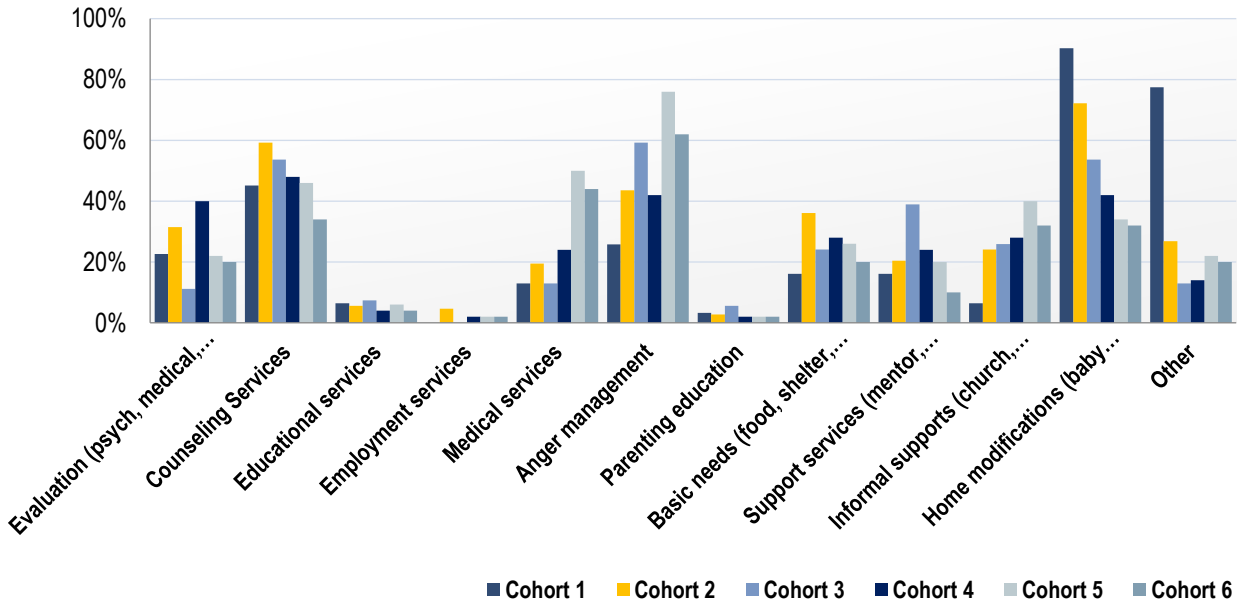
The challenges most often reported by staff are the time it takes to prepare for and conduct the meeting, schedule time to meet with families, and find a location to hold the TDM meeting. Interviewees reported challenges for Garrett's Law cases where the

mother had a C-section, suggesting the ability to meet with the client, under this special circumstance, is in the hospital after the mother has given birth.

Participation

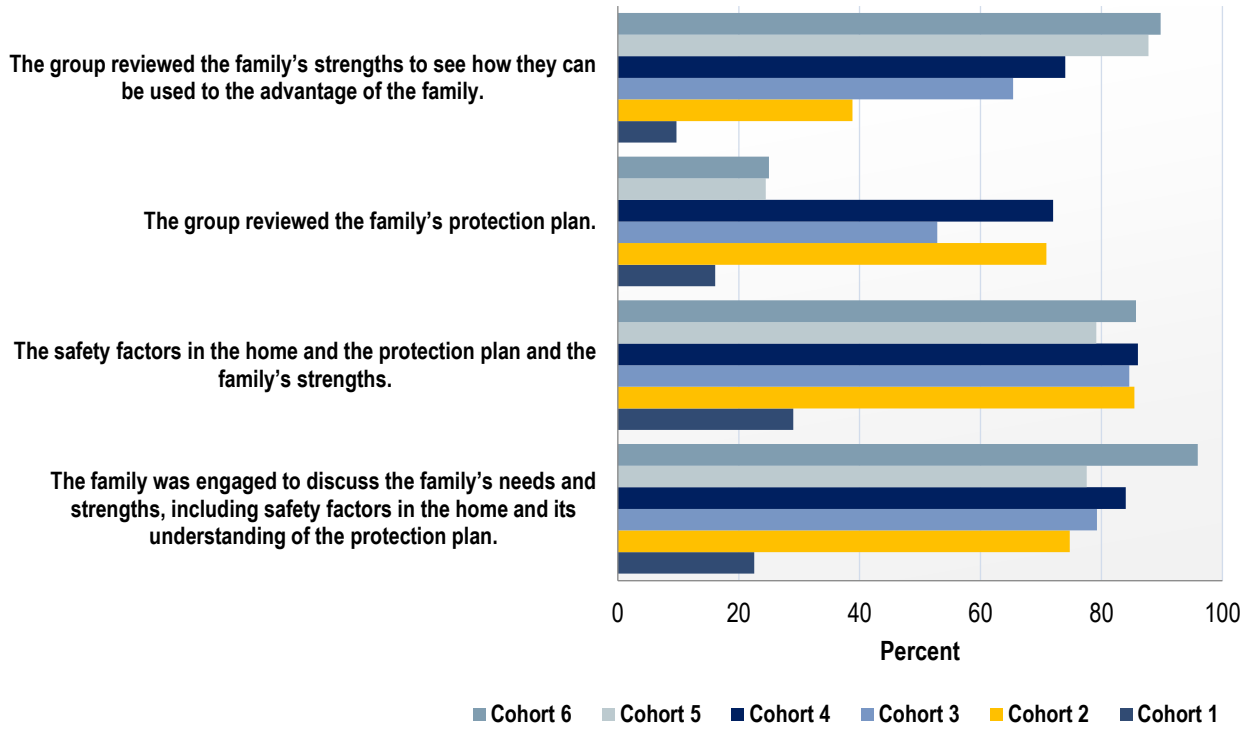
The case record reviews identified the types of services to which families were commonly referred as a result of the TDM meeting. Results are displayed in Figure 9. Over the course of the demonstration, referrals for medical services, anger management, and informal supports occurred more frequently. In comparison, a decreasing percentage of referrals for counseling services, basic needs, and home modifications were observed over time. The data also suggest that education, employment, and parenting services were underutilized in comparison to other types of services.

Figure 9. Types of Services Referred in TDM Meeting



The case reviews also examined the fidelity of the meetings to the TDM model. Overall, with the exception of the review of the family's protection plan indicator, the data suggest that TDM meetings were being held with fidelity to the model, particularly for those indicators which focus on the family's contribution to the process (Figure 10). This suggests that the teams conducting the meetings have improved their facility with the meeting process and have internalized the importance of focusing on strengths and family engagement in Team Decision-Making.

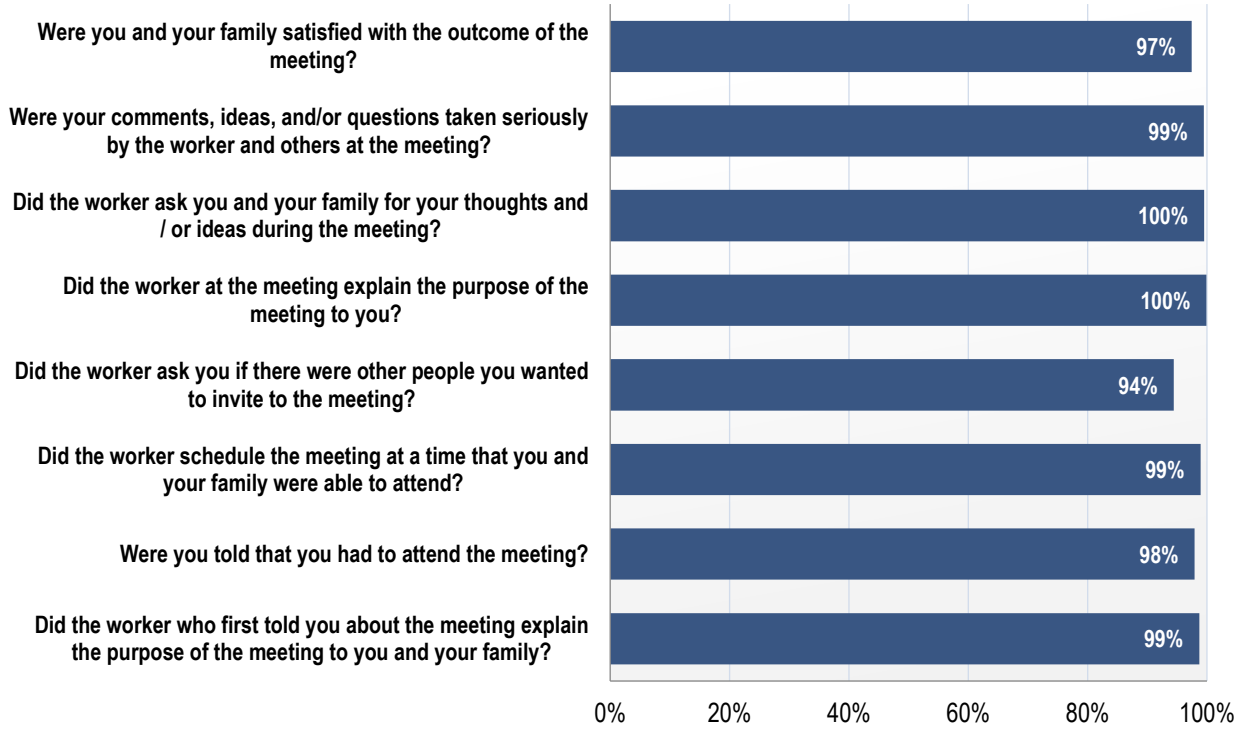
Figure 10. Percent the Following Statements Occurred in the TDM



Family Perspective

In the surveys to families, parents/caregivers were asked to rate their sense of involvement in the TDM meeting, as shown in Figure 11. Most respondents either agreed or strongly agreed that they were able to share their thoughts and opinions in the meeting, that their thoughts and opinions were valued, and that they felt like they were part of the team. Parents and caregivers overwhelmingly indicated they left the meetings knowing what they had to do to keep their children safe in their home and agreed with the decisions made in TDM.

Figure 11. Percentage of Families Responding "Yes" to the Following Questions



On the survey, families were given space to describe why they were or were not satisfied with the TDM meeting. Of the 258 families who took the opportunity to provide feedback, 66 percent of the comments received were positive, 29 percent were neutral, and only five percent were negative. This trend was evenly dispersed throughout the demonstration period, though there was a slightly higher percentage of negative comments in the initial phases of the initiative.

The clearest trend emerging from the neutral responses was the respondents' willingness to do anything for their children to keep them in the home. One family responded, "No matter what I have to do to keep my children I will do any services provided that will help me I will gladly accept." Respondents who gave negative feedback would typically criticize the involvement of DCFS in their family's lives (4 respondents), note that caseworkers were judgmental toward them (4 respondents), or complain of logistical challenges related to the scheduling of the meeting (3 respondents).

Positive comments about the TDM meeting were dominated by the families' appreciation for the nonjudgmental and open atmosphere in the meetings. A typical response reads, "I am comfortable around these people here that held the meeting. They were all helpful and make me feel like I wasn't being judged for my previous actions."

Overall, the mostly positive sentiments of families were echoed by the staff who were interviewed, with six stakeholders reporting the meetings gave families a voice and opportunity to be involved in the case planning process. Staff further reported that TDMs provide an opportunity to discover family strengths and resources which can be used to help prevent removals. Some staff reported that because the TDM occurs almost immediately after a concerning incident, it allows staff to "strike while the iron is hot" and it "seems to wake the family up to the problems they truly face and the work that needs to be done to overcome them."

Discussion

Successes and Strengths

Families overwhelmingly report being satisfied with TDM meetings, in particular the openness and nonjudgmental atmosphere in which they are conducted. Staff also gave positive feedback on the process, as they note TDMs give families a voice and provide an opportunity to highlight their strengths and available resources. The number and types of services to which families were referred changed throughout the demonstration period, with an increase in referrals to medical services, anger management, and informal supports; and a decrease in referrals for counseling services, basic needs, and home modifications. Coupled with the steady upward trend in the discussion of the family's strengths and engagement in the TDM meetings, it is reasonable to speculate that the TDM meetings helped FSWs to better identify the services families need. In addition, families overwhelmingly reported feeling more engaged which should lead to greater buy-in from families and a more positive relationship with DCFS.

Challenges and Limitations

Some DCFS staff expressed concern about a lack of support from both local legal teams and judges. One Area Director reported that the Office of Chief Counsel does not support protection plans and would rather remove a child, adding that this increases the number of children placed in foster care. Another DCFS staff member described a struggle with the courts because judges may still order a child into care, even after having the TDM.

Supervisory staff have indicated that TDM buy-in is a concern. One Area Director mentioned that caseworkers do not understand the purpose of TDM, while another stated that TDM has been the hardest initiative for which to obtain staff buy-in because there is a lot of confusion about when they need to create a protection plan. Nearly all FSWs who were interviewed report that the activities associated with TDM meetings are time consuming. Specifically, convening a meeting with multiple participants is logistically challenging, and follow-through with the action steps are difficult to document.

A few staff reported that scheduling the TDM meeting at a time that works for the family and staff can be a challenge with the meeting needed to be held within such a short window of time. Similar to that found among supervisors, staff also reported that TDMs can be very time consuming. One Area Director stated, "Some last an hour or two, but some last days. We had one that lasted six hours and we ended up removing the child

anyway, so it felt like a waste of time. And that impacts your staff and their ability to get their other work done." Other staff reported that getting families to comply with the plan resulting from the TDM can be rather difficult, with one staff member reporting that perhaps the plans are not as strong as they should be.

Right from the start of the initiative, challenges were encountered. It was difficult to find qualified applicants for the FSW Specialist positions, which contributed to a delay in the initial implementation of TDM meetings.

Outcome Study

Comparison/Cohorts

To measure outcomes, a comparison group was selected from the pool of protective and supportive service cases that had an initial protection plan completed between September 1, 2012 and August 31, 2013, *i.e.*, prior to implementation of the Waiver. The TDM portion of the Waiver was implemented beginning in September 2014; as such, the experimental cohorts are defined as cases for which a TDM meeting was conducted in every six-month period following the date of implementation until the end of the demonstration in July 2018. The dates and sizes of the experimental and treatment cohorts are shown in Table 20.

Time Frame	Treatment Group		Comparison Group	
	Cases	Children	Cases	Children
Cohort 1 (9/1/2014 – 2/28/2015)	32	62	32	56
Cohort 2 (3/1/2015 – 8/31/2015)	204	489	204	420
Cohort 3 (9/1/2015 – 2/29/2016)	297	641	149	308
Cohort 4 (3/1/2016 – 8/31/2016)	338	722	169	336
Cohort 5 (9/1/2016 – 2/28/2017)	294	639	147	290
Cohort 6 (3/1/2017 – 8/31/2017)	332	686	166	332
Cohort 7 (9/1/2017 – 2/28/2018)	353	754	177	349
Total	**1,850**	**3,995**	**867**	**1,742**

Table 20. Team Decision-Making Outcome Analysis Cohorts

Sample

Cases selected into the comparison cohorts were selected using propensity score matching; this technique matched a control group that mirrored the characteristics of the treatment group. Propensity scores were generated for each case in the treatment group using the service area, number of male children in the case, number of female children in the case, average age of the children in the case, primary race and ethnicity of the family, allegations associated with the case, and prior agency involvement as match criteria. Starting in Cohort 3, the size of the comparison and treatment group populations became similar; therefore, it became necessary to reduce the size of the treatment group matched to the comparison pool to half. This reduction still provides a sufficiently large comparison pool to measure outcomes in relation to those of the treatment group, while also being

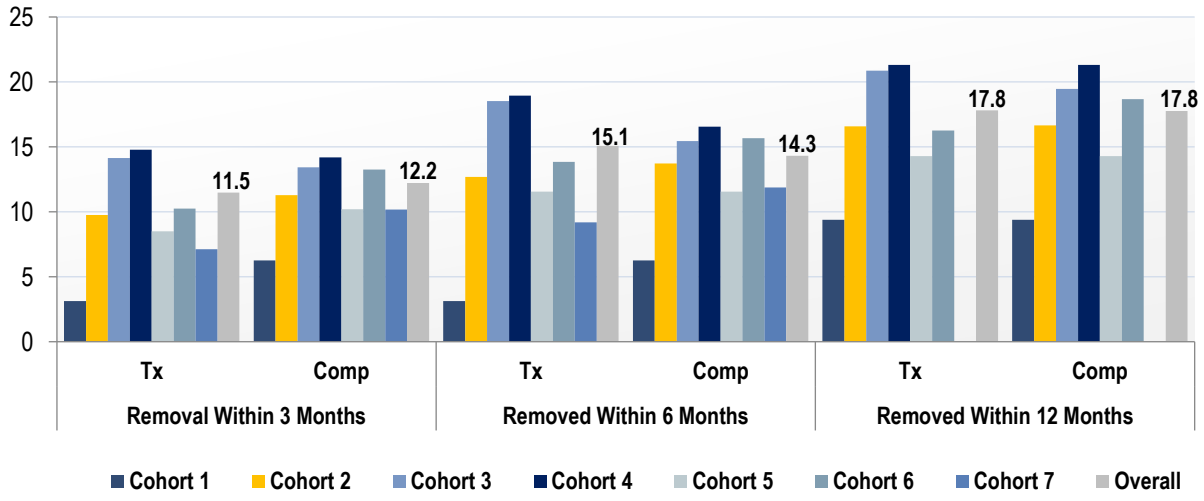
statistically similar to the treatment group. Only matched treatment group members are used in the analysis.

Results

Removal from the Home

TDM meetings are designed to place the child in the safest environment available and, whenever possible, keep the child safely in the home as services are provided to the family. Figure 12 shows the percentage of cases where at least one child was removed from the home within three, six, and twelve months of the meeting—or in the case of the comparison group, following development of the protection plan. Generally, cases from the treatment and comparison groups show similar percentages of removals per cohort with mixed results overall, both in the short-term (within three months) and longer-term (within twelve months). None of the differences observed are statistically significant.

Figure 12. Percentage of Cases with at Least One Child Removed

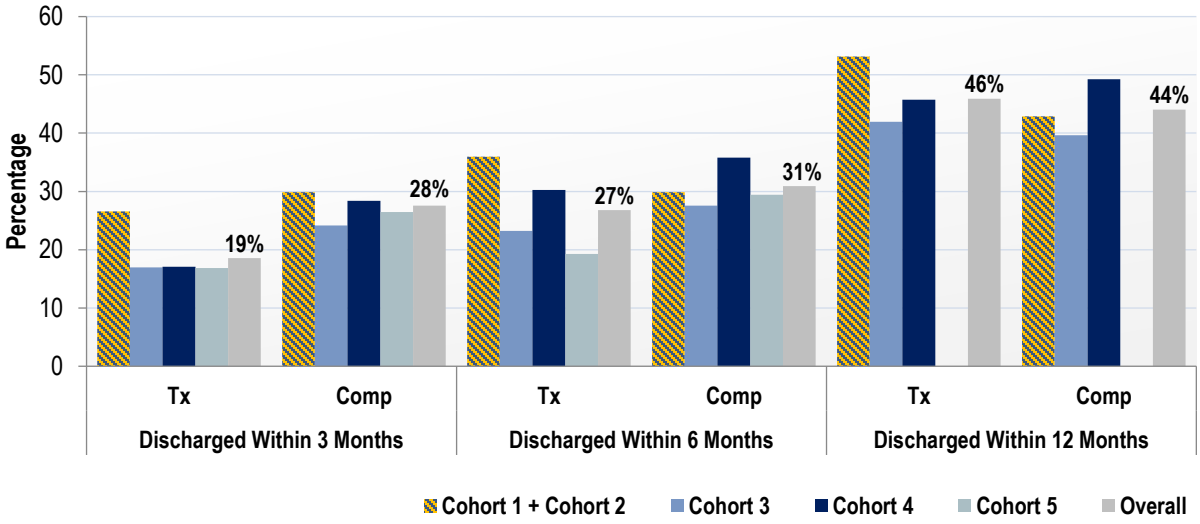


Discharge from Substitute Care

In the event that a child was removed from care after the TDM took place, it is possible that the action plan laid out in the meeting also served to help bring the child home more quickly. Figure 13 displays the percentage of children who were removed from their home within twelve months following the TDM meeting or development of the protection plan, for children in the comparison cohorts, and were subsequently reunified with their families or placed into relative custody. Cohorts 1 and 2 were combined in this figure to provide more meaningful results since only three children were removed from the home in the first treatment group. Outcomes are displayed where enough time has passed to measure impact.

In Cohorts 3, 4, and 5, there was a significantly lower percentage of treatment group youth discharged within three months of entry then comparison group youth. Overall, a slightly higher proportion of treatment youth are reunified within twelve months of entering foster care than comparison group cases, though the result was not significant.

Figure 13. Percentage of Children Discharged to Reunification



Discussion

The outcome evaluation provides little indication of a strong treatment effect for TDM as it was implemented in Arkansas during the demonstration period. Contrary to the outcome hypothesized, TDM cases show similar rates of removal for children in the treatment group as those in the comparison group. Interestingly, the types of cases encountered appeared to change throughout the demonstration period, with both experimental and matched controls showing an increasing number of cases where at least one child was removed through the first four cohorts before dropping again in the fifth and sixth cohorts.

Reunification results were likewise mixed. In the most recent reporting period for which sufficient time has elapsed, significantly fewer youth were reunified within three months

of their removal following the meeting than was the case for the comparison group. Over the lifetime of the demonstration, however, the percentage of reunifications within the cohorts was essentially flat for the treatment and comparison groups. The comparison group did show a consistently higher percentage of discharges within the three-month period, though the results for the six and twelve-month periods were again mixed.

An interesting finding arising during the staff interview process may help to at least partially explain the weak relationships observed, specifically that DCFS staff indicated that it is difficult to get buy-in from the larger system in which they are operating, and that it is difficult to get families to later comply with the plan developed at the TDM meeting. In particular, there is a limited exchange of information from the TDM facilitator to the caseworker responsible for the case after the TDM is conducted. These issues suggest broader systemic factors that influence how any single intervention can be evaluated. In sum, the overwhelmingly favorable impression of the TDM process by families and DCFS staff and the changes observed in service referral suggest that TDM is a process that bears further study.

Cost Study

Similar to the cost analysis for Differential Response, Table 21 displays the cost of room and board payments for children who were removed from their homes following the TDM. It also includes service payments for family members. Costs for maintenance and services are calculated for up to twelve-months following the TDM meeting for the treatment group and date of the initial protection plan for comparison group members. Two of the five cohorts showed a cost savings per family compared to the historical group with Cohort 1 showing the largest savings per family ($4,200). Cohort 5 has the highest cost deficit per treatment group family (nearly $1,100). Overall, the treatment group costs are roughly $375 more per family than the comparison group.

As noted in the outcome evaluation, TDM shows similar percentages of cases with youth removed from the home and slightly longer time frames to reunification. Table 21 also shows the majority of the treatment group cost-differential comes from foster home costs. Youth removed after a TDM spent over 25,000 more nights in these settings than youth in the comparison group. However, congregate care usage is slightly lower for youth after a TDM who spent roughly two percent less time in these settings than comparison group youth.

Cohort	Total Number of Families	Total Foster Care Costs	Total Congregate Care Costs	Total Service Costs	Average Cost per Family
Treatment Group					
1	32	$1,315.86	$4,343.20	$186.25	$182.67
2	204	$123,781.92	$174,813.80	$9,145.15	$1,508.53
3	297	$338,278.34	$339,638.24	$5,042.50	$2,299.53
4	338	$436,110.50	$363,308.68	$5,418.75	$2,381.18
5	294	$337,709.62	$239,527.48	$12,882.29	$2,007.21
Total	**1,165**	**$1,237,196.24**	**$1,121,631.40**	**$32,674.94**	**$2,052.79**
Comparison Group					
1	32	$12,627.24	$122,478.24	$5,129.06	$4,382.33
2	204	$146,164.28	$268,301.18	$10,227.13	$2,081.83
3	149	$139,016.65	$78,286.18	$2,318.58	$1,473.97
4	169	$147,756.51	$183,717.36	$9,418.38	$2,017.11
5	147	$89,083.94	$39,197.38	$0.00	$872.66
Total	**701**	**$534,648.62**	**$691,980.34**	**$27,093.15**	**$1,788.48**

Table 21. Maintenance and Service Costs for TDM

Nurturing the Families of Arkansas

Nurturing the Families of Arkansas, implemented in March 2015, is an evidence-based child abuse and neglect prevention and treatment program for families. NFA was designed as a family centered, trauma informed program which promotes nurturing parenting skills. In 2012, a committee made up of individuals from around the State with experience in parent education selected the Nurturing Parent Program (NPP) as the parenting program Arkansas would implement as one of its Title IV-E-Waiver Initiatives. The University of Arkansas at Little Rock (UALR) MidSOUTH Center for Prevention and Training was selected to provide the program. NPP was customized for Arkansas and renamed to Nurturing Families of Arkansas.

NFA targets parents with children from ages 5–11 who are involved with DCFS due to abuse or neglect. The age range was expanded to include youth up to 18 in January 2018. Services included fostering positive parenting skills, educating parents about healthy brain development and engaging families in in-home practice exercises. Within 30 days of a referral, a Comprehensive Parenting Inventory (CPI) is completed in the family's home to determine the strengths and needs of family members. A Family Nurturing Plan is then created at a second home visit taking the family's knowledge, attitudes, and history into account. The NFA program was administered in-home to families and/or in group classes at central locations, depending on the capacity of the Service Area, the volume of referrals in a particular region, and/or the needs of individual families.

Central Office staff worked closely with NFA's creator, Dr. Stephen Bavolek, to customize the program to meet the specific needs of Arkansas's families. For example, DCFS created a new role for Program Assistants (PAs). The PAs had established relationships with the families, often spending more time with them than the Family Service Workers. However, the PAs did not meet the requirements to be Parent Educators, *e.g.*, having a degree in social work and four or more years' experience in a social field. Instead of discarding the value of PAs, they were utilized by creating the Parent Coach position within the NFA program. The job responsibilities of Parent Coaches include assisting with transportation and childcare, as well as supervising parents and caregivers in their home as they interact with their children, which helps to promote the lessons learned in the NFA program. The basic structure of the program is that DCFS Family Services Workers make referrals to MidSOUTH based on the needs and eligibility of families, families receive the NFA services from MidSOUTH's Parent Educators and DCFS Parent Coaches support families in utilizing the skills and knowledge they learn from NFA.

Process Study

Sample

Approximately 15 to 20 interviews were conducted annually with various Division of Children and Family Services and MidSOUTH staff. Initial interviews assessed the readiness of stakeholders to administer the NFA program. Subsequent interviews asked questions regarding preparation and ongoing implementation of the program, supervision

of workers, and capacity to meet demand for the program. Stakeholders from all ten service areas were interviewed. Those interviewed include Family Service Workers and their Supervisors, County Supervisors, Parent Coaches, Area Directors, and MidSOUTH Parent Educators.

As families graduated from NFA, they were asked to complete a survey which addresses the families' interactions with the NFA instructor, the strengths and weaknesses of the program, and their perception of the effectiveness of the program. A total of 262 surveys were completed by families participating in the NFA program.

Reporting Period	Surveys
1. March 2015 – August 2015	18
2. September 2015 – February 2016	30
3. March 2016 – August 2016	42
4. September 2016 – February 2017	35
5. March 2017 – August 2017	47
6. September 2017 – February 2018	34
7. March 2018 – August 2018	56
Overall	**262**

Table 22. Cohorts and Number of Surveys Completed

From March 2015 through February 2018, 538 families participated in the NFA program. Of those, 369 successfully graduated or were still attending sessions (Table 23).

Cohort	Graduated / Active	Dropped Out
1. March 2015 – August 2015	69	44
2. September 2015 – February 2016	55	16
3. March 2016 – August 2016	62	31
4. September 2016 – February 2017	50	18
5. March 2017 – August 2017	60	15
6. September 2017 – February 2018	78	51
7. March 2018 – July 2018*	58	28
Overall	**432**	**203**

* Not enough time has passed to measure graduation occurrences for Cohort 7. The number of people enrolled in Cohort 7 are shown but not included in the Overall total.

Table 23. Count of NFA Participants and Comparison Group Size

Results

Demographics

Table 24 shows the number of NFA families and youth involved in addition to the percentage of those families/children by Service Area and demographics, broken down by six-month cohort. Implementation across the state was moderately inconsistent over time. The percentage of cases referred in each Service Area varies from cohort to cohort and can jump by as much as 15 percentage points. Similarly, the race of the children varies over the lifetime of the Waiver. Typically, two-thirds of the children are between five and 14, which are roughly the age ranges NFA is intended to serve (ages five to 11).

Demographic	Tx 1	Tx 2	Tx 3	Tx 4	Tx 5	Tx 6
Number of Cases	113	71	93	68	73	129
Number of Youth	284	157	234	213	217	373
Area						
Area 1	2%	7%	3%	7%	3%	2%
Area 2	14%	19%	10%	10%	15%	16%
Area 3	7%	17%	13%	7%	21%	14%
Area 4	9%	4%	3%	15%	8%	11%
Area 5	9%	4%	1%	0%	3%	3%
Area 6	14%	10%	9%	4%	15%	8%
Area 7	6%	3%	12%	6%	3%	4%
Area 8	17%	7%	22%	13%	9%	24%
Area 9	9%	10%	8%	10%	11%	9%
Area 10	14%	19%	19%	24%	13%	11%
Gender						
Male	48%	61%	54%	52%	50%	50%
Female	54%	41%	52%	48%	50%	50%
Race/Ethnicity						
Black	33%	13%	23%	35%	36%	23%
White	57%	80%	74%	63%	51%	67%
Other	12%	9%	10%	2%	12%	10%
Hispanic (Ethnicity)	4%	6%	3%	7%	8%	6%
Age						
Age 0–4	33%	25%	29%	31%	29%	27%
Age 5–9	40%	43%	46%	41%	43%	40%
Age 10–14	23%	31%	25%	22%	21%	26%
Age 15–17	5%	3%	7%	5%	7%	7%

Table 24. Demographic Information for NFA Cases

Organizational Readiness

Prior to implementation of NFA, staff from DCFS and MidSOUTH were interviewed to assess their readiness to implement the NFA program. DCFS began preparing staff for NFA implementation in October 2014. Area Directors held monthly staff meetings with supervisors, and supervisors met with their staff to discuss implementation of the initiative, as well as to respond to their questions and concerns. All staff received emails about the launch of the program, referral criteria, updates, and clarification about the program (*e.g.*, changes to the referral criteria). MidSOUTH played an integral role in readiness activities by attending Central Office, Supervisor, and Area Director meetings and developing fliers to promote the program. They also connected with FSWs to advise and collaborate on how to spread the word about the program to parents.

Staff Training

Dr. Bavolek and MidSOUTH staff provided two trainings for DCFS staff about the NFA program. The first training was a three-day orientation for specific staff that would be involved with the NFA program (*e.g.*, Parent Coaches and Supervisors). The second training was a three-hour overview of NFA for all staff, where criteria for NFA referrals were reviewed.

Staff reported mixed reactions to the NFA training, with some stating that they were "somewhat" prepared to begin the program. While some staff reported the training was adequate, others stated that it was too long, and that the presenter discussed the philosophy of parenting, rather than the "nuts and bolts" of the program. Some staff were turned off with the discussion of corporal punishment, because the program's philosophy regarding corporal punishment conflicted with their own beliefs. Staff reported that they would have benefited from a shorter training, more specific descriptions of the program, and more information on how to make referrals. A number of staff reported that additional training was needed. Some workers thought that all staff should have had the opportunity to be trained on NFA in the beginning of the program, rather than starting the program with only some staff trained, arguing that training everyone from the beginning could have increased knowledge of the program and referrals. Staff requested on-going training be provided so that new staff have the opportunity to be trained in the event of turnover.

There were over 200 DCFS Program Assistants across the state and only a portion were trained in NFA to fill the role of Parent Coaches. MidSOUTH contracted with Southern Arkansas University (SAU) to conduct training in June 2015 for the remaining Program Assistants who had not been trained. Parent Educators were trained by the MidSOUTH program managers. Parent Educators reported having enjoyed the training they received and stated it was informative and the role-play activities were beneficial in providing scenarios of how NFA would be effective.

Family Nurturing Plans

Parent Educators conduct a visit with families shortly after the initial CPI assessment to create a family-specific needs-based plan. The Family Nurturing Plan (FNP) promotes a partnership between parents and professionals to work together in creating a parenting program that meets the specific needs of the family. To be successful, parents need to demonstrate competence in the core lessons that form the foundation of Nurturing Parenting. FNPs were designed to increase parental commitment to attending and participating in the NFA classes and to the skills taught there.

Table 25 shows the percentage of families that created an FNP with staff, and the average number of days between the CPI assessment and FNP. Overall, 92 percent of the families successfully developed an FNP with a Parent Educator within an average of 10 days of the initial CPI assessment. For the families that did not complete an FNP, common reasons included DCFS closing the case or referring the families to another program after completion of the initial CPI assessment. Additionally, the time to complete the FNP has decreased substantially for parents starting the program after September 2016.

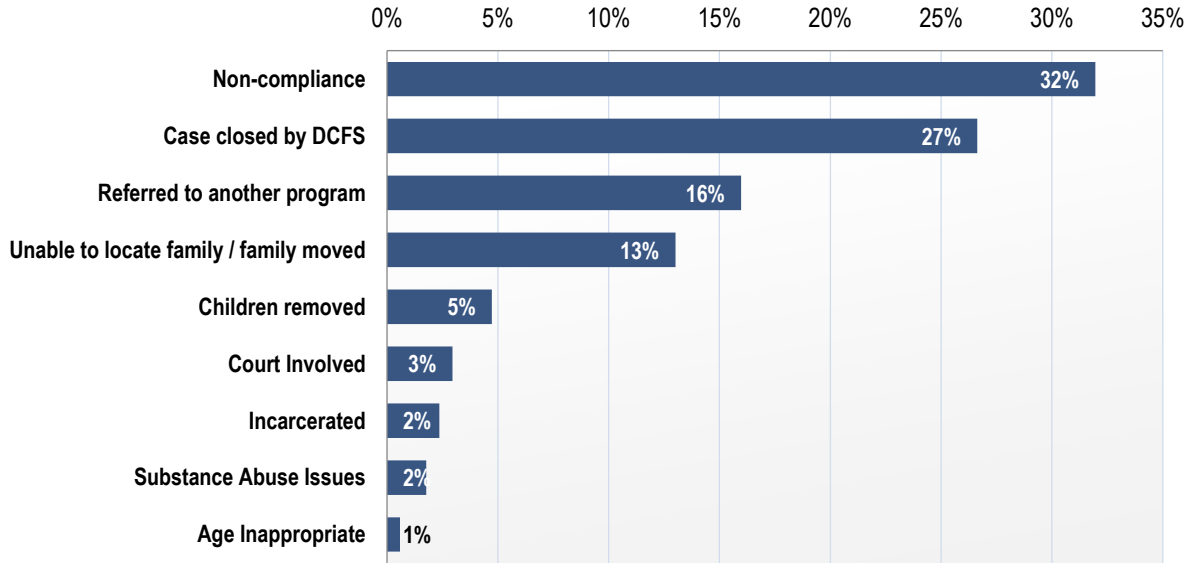
Cohort	Participants	Percent with FNP	Average Number of Days Between CPI and FNP
1. March 2015 – August 2015	113	88%	13
2. September 2015 – February 2016	71	92%	12
3. March 2016 – August 2016	93	87%	14
4. September 2016 – February 2017	68	99%	7
5. March 2017 – August 2017	73	99%	6
6. September 2017 – February 2018	129	94%	8
7. March 2018 – August 2018	86	–	–
Overall	**633**	**92%**	**10**

Table 25. Count of NFA Participants FNP Completion

Family Engagement

Approximately 69 percent of the families either graduated the NFA program or were still actively attending sessions. Overall, the top reasons for dropping out of the NFA program were non-compliance, case closure by DCFS, and referral to another program (Figure 14). Cohorts 1 and 6 suffered the largest non-completion rates (Table 23), with non-compliance and DCFS closing the case as the most common reasons. Cohort 6 also saw a higher percentage of families referred to another program. Cohorts 2, 3, 4, and 5 had relatively low non-completion rates.

Figure 14. Reasons for Families Dropping Out



Upon graduation of the NFA program, families were asked to complete a survey to provide feedback on their experience with the program. Between 83 and 98 percent of families within each cohort completed all 16 classes, for an overall attendance rate of 89 percent; the lone exception was families in Cohort 3 (67 percent). Of the families who were unable to attend all 16 sessions, most cited medical issues preventing them from attending and were able to make up the classes at a later date. Families were asked where they attended sessions: in their home, in a group setting with other parents, both, or neither. Overall most families reported attending sessions in their own home or in a group setting with other parents, but not both.

Most parents reported that their children attended all or some of the classes with them (68 percent overall). Of parents who reported that their child did not attend class with them, nearly all reported that their child attended a separate class at the same time (90 percent overall).

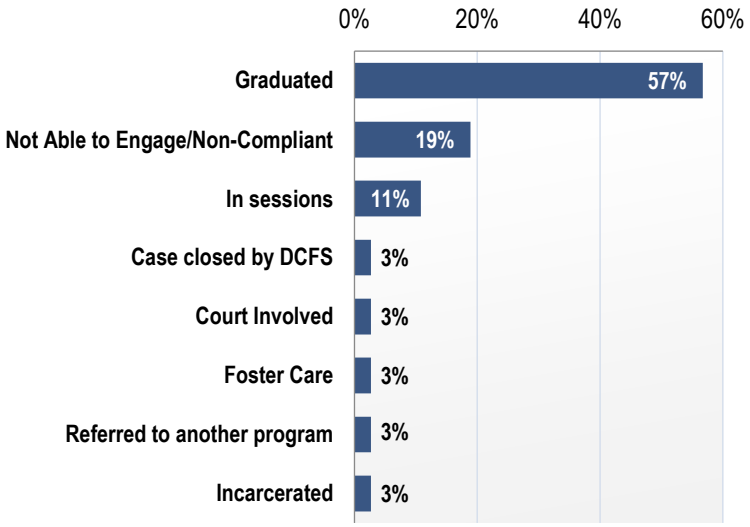
The survey offered families the opportunity to rate, on a scale of 1 to 4 or Strongly Agree to Strongly Disagree, their engagement with the instructor and the impact of the NFA program on their families. Overwhelmingly, families reported good communication with their instructor, with families also indicating the instructor focused on their positive qualities as a parent. Instructors were found to have treated families with respect and modeled good parenting behaviors. Overall, parents agreed that they learned valuable skills to improve their parenting and parent-child relationships. When asked to comment on what parents liked the most, many indicated they like learning new techniques that help to “build a strong foundation for [their] family,” and they enjoyed the interactions with the instructor. When asked to comment on any barriers to success, parents reported that the inconvenient class times and the long length of the program (16 weeks) were obstacles.

Parent Coaches

The position of Parent Coaches, which is comprised of DCFS' Program Assistants, was established given the rapport such staff already have with families. Parent Coaches support families in applying and reinforcing the knowledge learned at NFA sessions.

Overall 37 families were assigned to a Parent Coach to help them with the NFA program. There were a limited number of Parent Educators available to assist families, therefore not as many families received the specialized coaching. Figure 15 shows that 68 percent of the families with a Parent Coach either graduated the NFA program successfully or were still attending sessions. The remaining 32 percent of families assigned a Parent Coach were non-compliant, referred to another program, or otherwise unable to continue with the NFA program.

Figure 15. Results of Cases with Parent Coaches



The success rate of families assigned a Parent Coach (68% graduated or in session) was similar to that of all families (69%). This data suggests parent coaches do not promote higher graduation rates, and thus are likely not a key component of the Nurturing Family model.

Discussion

Successes and Strengths

Experienced Staff

The Parent Educators of MidSOUTH were highly praised for their professionalism, friendliness, and expertise. Families enjoyed their interactions with the Parent Educators and overall had positive experiences. MidSOUTH worked with DCFS to create a position for the Program Assistants. As Parent Coaches, these staff supported the families with visits to promote the skills and knowledge learned in the NFA classes. With the combined value of the MidSOUTH Parent Educators and the DCFS Parent Coaches, the NFA program had staff with experience and expertise.

Family Satisfaction

Families who graduated from the NFA program expressed overwhelming satisfaction with the program. Survey respondents found that Parent Educators were well received. Families noted having good communication with the Parent Educator, as well as the Educators' highlighting positive qualities of the parents, treating families with respect, and modeling good parenting behaviors. Parents generally reported that they learned valuable skills to improve their parenting and relationships with their child(ren) from the Parent Educator.

Challenges and Limitations

Families with Substance Abuse

A prominent criticism of the NFA referral criteria was the exclusion of families involved with substance abuse. Families are only eligible for NFA if substance misuse is not a current issue. In the case that substance misuse is a current issue, the family is eligible only if the parent(s) is/are actively participating in treatment. According to staff, this criterion automatically disqualified the majority of families in the child welfare system that would otherwise have been eligible for NFA.

Interviews that were conducted with staff further into implementation of the program found that the NFA eligibility criteria were expanded to include some families with substance abuse issues. However, the change had not been clearly messaged to the referring staff, and in most Areas families newly eligible under the expanded criteria were not being referred to NFA.

Reconciling Views of Corporal Punishment

Some staff also expressed disagreement with NFA's philosophy on corporal punishment, which is to say that the model discourages corporal punishment and categorizes it as abuse, an approach with which some DCFS workers do not agree. Because the NFA discourages families from using corporal punishment, some workers who were expected to reinforce and encourage that framework struggled to reconcile it with their own beliefs and identified their disagreement with the model as a barrier to implementation.

Logistics in Attending Classes

Some families had difficulty attending the program classes due to transportation or scheduling issues. For example, a family may not have transportation, cannot afford transportation, or may have trouble finding the time to attend all 16 classes. The NFA program was able to solve these problems for many families by providing transportation, rescheduling classes, or conducting classes at the family's home.

Outcome Study

Comparison/Cohorts

Six-month cohorts are also used to measure outcomes. The analysis of outcomes is limited to the five cohorts for which at least six months have passed since all families either graduated or dropped out of NFA, *i.e.* families who started NFA between March 1, 2015 and February 28, 2018. Data sources used for the analysis are from both MidSOUTH, who provided the list of NFA participants as well as CPI scores and participation status, and CHRIS, which contained information on future maltreatments or removals.

A comparison group of families who had a Protective or Supportive Services case open between March 1, 2013 and February 28, 2015 were selected to compare the effectiveness of similar type cases whose families participated in the NFA program. Comparison cases, using propensity score matching, were selected based on the families' Service Area; number of children in the household by gender and average age of the children; racial and ethnic make-up of family members and prior agency involvement. Propensity scores of the treatment group were compared to those of the comparison group, with families selected based on a nearest neighbor algorithm.

Results

Improving Parenting Skills

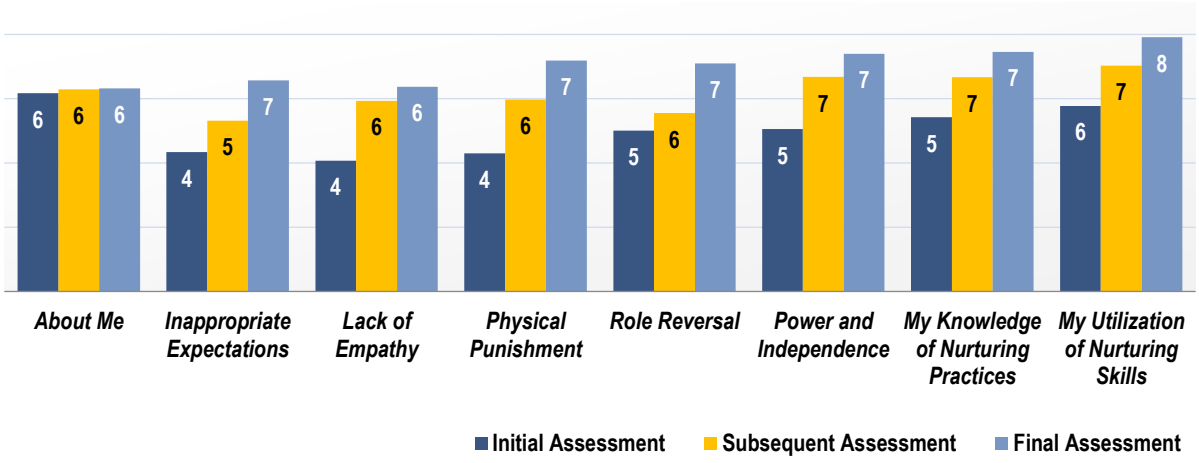
During the course of the 16-week NFA program, three Comprehensive Parenting Inventory assessments are administered to the parent, one at baseline, one during the program, and a final assessment upon completion of the program. Using a ten-point scale, with one representing a low score and ten a high score, the assessments are used to track the progress of parents in developing needed skills and their abilities to care for their children. Eight parenting skills are used to measure the nurturing and caring capacities of families.

1. *"About Me"* which assesses the quality of life the parent provides for themselves and their children;
2. *"Inappropriate Expectations"* which explores the expectations the parent has of their children based on the child's developmental needs;
3. *"Lack of Empathy"* which examines the response of the parent toward meeting their own needs and helping their child(ren) meet their needs;
4. *"Physical Punishment"* which assesses the disciplinary practices used in teaching and guiding the parent's child(ren);
5. *"Role Reversal"* which explores having appropriate roles for adult and child members of the family;

6. *"Power and Independence"* which examines how the parents encourage their child(ren) to develop their personal power and independence;
7. *"My Knowledge of Nurturing Practices"* which examines the parent's knowledge of various nurturing family practices; and
8. *"My Use of Nurturing Skills"* which measures the frequency the parents use nurturing skills and strategies in their own lives as well as their child(ren)'s.

Figure 16 displays the average scores of participants at the time of their initial, interim and final assessments, broken down by parenting skill for participants who graduated and entered the program between March 2015 and February 2018. Parents reported having better parenting skills during their final assessment compared to their initial assessment on a variety of topics including empathizing with their child, having appropriate expectations with their child, and enabling their child to have power and independence. The one exception, with relatively minimal change from baseline to discharge, is found in the "About Me" domain, which assesses the quality of life the parent is able to provide for themselves and their child(ren).

Figure 16. Average Score on CPI Assessment for All Cohorts - Graduated Participants



Subsequent Maltreatment Allegations and Removals

With these improved parenting techniques, one of the objectives for the NFA program is to keep children safely in their homes following completion of the program. Table 26 presents the number of families that have a subsequent verified maltreatment report as well as those families that have a child removed from the home. The number of removals and verified maltreatment reports were counted if they occurred within three, six, and twelve months of graduating NFA for the treatment group or within the same time frame of case opening for the comparison group. Cohort 6 is not included in the analysis since only seven of those who graduated have six-months available to measure outcomes.

Families in Cohorts 1 and 3 that graduated NFA were either as likely or less likely than the comparison groups to have a child removed at three, six, and twelve months following graduation. Families in Cohort 2 that graduated NFA did not show improvement relative to the comparison group. The Cohort 5 treatment and comparison families did not have any removals. Overall, families that graduated NFA had slightly lower rates of child removal than the comparison groups at six and twelve months but not three months.

Families in Cohorts 1 and 3 that graduated NFA were significantly less likely to have a verified maltreatment report within twelve months than the comparison groups. In contrast, families from Cohorts 2 and 4 were more likely to have a verified maltreatment report within twelve months than the comparison groups. Families in Cohort 5 had reduced rates of verified maltreatment reports at three and six months than the comparison group. Overall, families that graduated NFA were slightly less likely to have a verified maltreatment report than the comparison group within three, six, and twelve months, though this result is not significant.

Time frame	Cohort 1		Cohort 2		Cohort 3		Cohort 4		Cohort 5		Overall	
	Tx	Comp	Tx	Comp	Tx	Comp	Tx	Comp	Tx	Comp	Tx	Comp
Child Removed from the Home												
3 months	2%	2%	2%	2%	2%	3%	4%	3%	0%	0%	2%	2%
6 months	2%	2%	4%	3%	2%	3%	6%	4%	0%	0%	2%	3%
12 months	2%	6%	4%	5%	7%	8%	9%	7%	–	–	5%	7%
Subsequent True Report												
3 months	3%	2%	4%	7%	3%	2%	2%	4%	0%	3%	2%	3%
6 months	5%	7%	7%	7%	3%	5%	2%	4%	3%	8%	4%	6%
12 months	8%	14%	16%	11%	5%	14%	11%	6%	–	–	10%	12%

Table 26. Percentage of Cases with a Child Removed from the Home, a Subsequent True Report, or Both Following NFA Graduation

Safety is defined as no child removed from the home and no subsequent true report. Table 27 shows graduating participants of NFA have similar or improved safety in the home within three or six months. Within twelve months, Cohorts 1 and 3 exhibit improved safety in the home relative to the comparison group, while Cohorts 2 and 4 have worsened safety in the home.

Overall, families who graduate the NFA program are 20 to 25 percent less likely to have a child removal or a new verified maltreatment report; this result is not statistically significant. This trend is not consistent over the lifetime of the initiative where Cohorts 2 and 4 treatment youth display slightly higher rates of removal and new reports than comparison youth.

Time Frame	Cohort 1		Cohort 2		Cohort 3		Cohort 4		Cohort 5		Overall	
	Tx	Comp	Tx	Comp	Tx	Comp	Tx	Comp	Tx	Comp	Tx	Comp
Child Removed from the Home or New True Report												
3 months	3%	3%	5%	7%	5%	5%	4%	6%	0%	3%	3%	4%
6 months	5%	8%	9%	8%	5%	7%	6%	7%	3%	8%	6%	8%
12 months	8%	16%	18%	13%	10%	17%	15%	10%	–	–	12%	15%

Table 27. Percentage of Cases with a Child Removed from the Home or a Subsequent True Report Following NFA Graduation

Discussion

NFA targets families with children between the ages of 5 and 18 years old who are involved with DCFS for abuse or neglect. NFA provides in-home assessments, family-specific plans, and parent education classes.

Between 150 and 200 families have participated annually in the NFA program since its implementation in March 2015. Approximately 31 percent of families do not complete the program, most often due to non-compliance in attending program classes. Of the families that do graduate, the vast majority report enjoying their interaction with Parent Educators and learning valuable parenting skills.

NFA was successful in improving parenting skills as measured by results from the initial and follow-up CPI assessments. Overall, safety in the home was slightly improved, though the results were not significant due to the limited number of families in the program.

Cost Study

Table 28 displays the cost of room and board payments, for children removed from their homes, and service payments for up to twelve-months following the graduation date or four-month mark after the initial CPI date for NFA participants not graduating or case opening for comparison group members. The vast majority of the difference in cost comes from the savings in congregate care costs (roughly $350,000 spent on youth in the comparison group to $120,000 for those in the treatment group). Only 11 treatment group youth were placed in congregate care in the two years measured below compared to 31 in the comparison group and spent one-third the time in this higher level of care. Interestingly, both groups had the same average length of stay in congregate care per child (103 days). For children placed in foster homes, however, those in the treatment group spent roughly 270 more nights in this setting than comparison group youth, even though fewer youth utilized these settings, leading to a slightly higher cost for foster homes. In general, the average cost per family was cheaper by nearly $800 for NFA families than comparison group families.

Cohort	Total Number of Families	Total Foster Care Costs	Total Congregate Care Costs	Total Service Costs	Average Cost per Family
Treatment Group					
1	107	$8,634.27	$0.00	$0.00	$80.69
2	68	$3,842.22	$4,017.46	$0.00	$115.58
3	91	$16,065.95	$74,160.14	$21.25	$991.73
4	68	$19,082.06	$45,277.86	$600.06	$955.29
Total	**334**	**$47,624.50**	**$123,455.46**	**$621.31**	**$514.08**
Comparison Group					
1	97	$6,189.45	$17,915.70	$0.00	$248.51
2	61	$6,508.57	$46,472.24	$19,575.00	$1,189.44
3	87	$15,004.31	$166,561.72	$1,225.00	$2,101.05
4	71	$13,174.86	$117,917.88	$872.50	$1,858.67
Total	**316**	**$40,877.19**	**$348,867.54**	**$21,672.50**	**$1,301.95**

Table 28. Maintenance and Service Costs for NFA

Arkansas Creating Connections for Children

Arkansas Creating Connections for Children was a statewide initiative implemented to recruit and retain foster and adoptive resource families. “Targeted Recruitment” was the name by which ARCCC is known under the Waiver, which serves Service Areas 3, 4, 5, 7, 9, and 10; “Diligent Recruitment” was the name by which ARCCC is known under the Diligent Recruitment grant, which served Areas 1, 2, 6, and 8. Targeted Recruitment was first implemented in February 2015 while Diligent Recruitment began three months earlier.

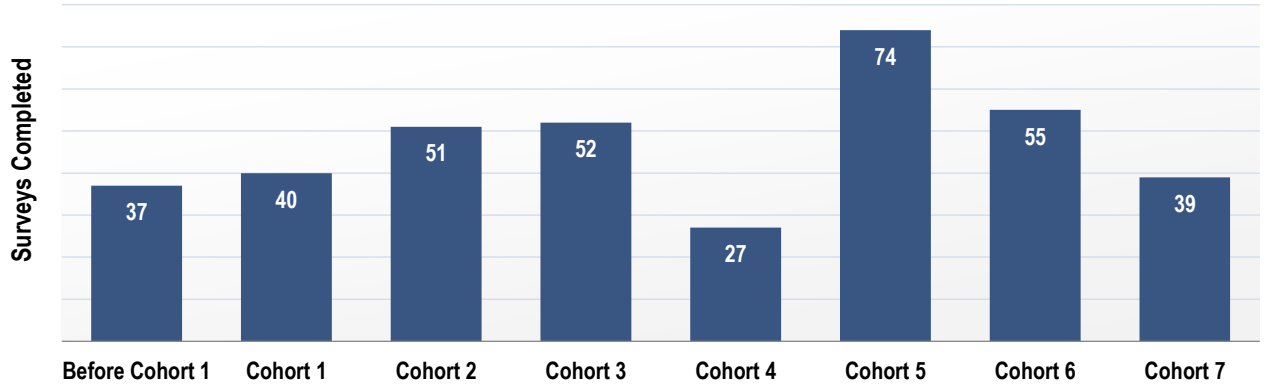
Since statewide implementation of ARCCC, 5,442 foster families have been recruited, 3,513 from the Diligent Recruitment service areas and 2,787 from the Waiver areas. The areas served by the grant covered a geographic area with a larger population, thus explaining why more homes were recruited in those areas. With the recruitment of targeted foster homes, youth should be placed closer to their biological parents, experience increased placement stability, and have reduced numbers in congregate care.

Process Study

Sample

In the month following approval to serve as a foster home, families were asked to complete a survey which addresses their perception of the recruitment process and its effectiveness. A total of 338 surveys were completed during the Waiver period, while 37 families were surveyed during the six months prior to implementation. A survey was administered to families who were recruited and approved prior to the start of ARCCC to provide a comparison of their perceptions to those recruited and approved under the Waiver initiative. Figure 17 shows how many resource families completed the survey during each six-month period, including prior to start of the program.

Figure 17. Completed Family Surveys by Cohort



A sample of case records was reviewed to assess child well-being and delivery of services to meet the needs of youth in ARCCC approved homes. Cases were selected among children who were placed in a newly approved home, selecting the cases from children placed during the twelve months prior to conduct of the case review. A total of 295 such case records were reviewed to inform the process evaluation. Using a structured instrument to collect data, questions focused on whether the children had any circumstances which may affect permanency (*e.g.*, medical or behavioral issues), services they received while in the ARCCC home, and whether the child or biological parents were consulted if a change did occur.

To gain the agency's point of view, between 20 and 40 key stakeholders, including Area Directors, ARCCC resource supervisors and workers, and Community Engagement Specialists (CESs), were interviewed annually about the ARCCC initiative. Questions focused on worker training, community partnerships, foster/adoptive family recruitment, foster/adoptive parent training, foster/adoptive family retention, and successes and challenges encountered in implementing the initiative.

To gain a better understanding of resource families' perspectives, HZA conducted focus groups with foster and adoptive parents who were involved with the child welfare system either before ARCCC was implemented (between February 2011 and February 2013) or after ARCCC was implemented (after February 2015). Six topics were addressed during the focus groups: process of gaining approval to foster or adopt, training for resource families, availability and quality of supports that are provided for resource families, lack of certain types of supports for resource families, challenges for resource families, and systemic changes which resource families believe would improve resource family recruitment and retention.

Focus groups were conducted in the spring of 2016 with resource families who were recruited before the implementation of ARCCC and in September 2016 with those who were recruited post implementation. One baseline focus group was scheduled in each of the 10 Service Areas but only nine were conducted as efforts to recruit participants in Area 2 were unsuccessful. Between three and nine individuals participated in each of the baseline focus groups. To improve the rate of participation, at least two sessions were scheduled in each Service Area for the follow-up focus groups, including one session which allowed resource parents to participate via conference call. Follow-up focus groups were held with one to seven families participating in each group.

HZA switched to in-person/telephone interviews during the project's final two years. HZA also changed its interview recruitment method, contacting foster and adoptive parents via email or phone as opposed to mailing letters. In all, interviews were conducted with 71 resource families.

Finally, documents from DCFS were reviewed which contained information related to policy changes, performance-based contracts, and staff qualifications and trainings. DCFS offices at the State, Service Area and county levels were asked to submit documents which illustrated their work on the project. Throughout the evaluation, the

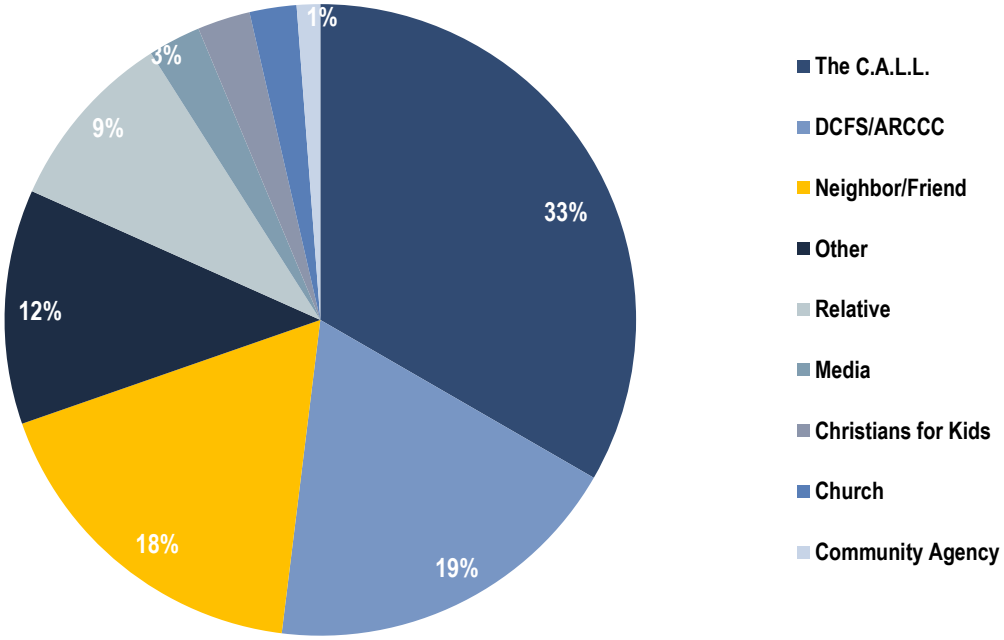
information gathered from the document reviews helped identify barriers to successful implementation and areas where improvements had been made.

Results

Recruitment

Families recruited under ARCCC were asked in the survey administered following their approval as resource homes where they heard about the opportunity to become a foster or adoptive parent. Figure 18 shows that most of the responding families learned about the opportunity to foster/adopt from The Children of Arkansas Loved for a Lifetime (The C.A.L.L.) (33%), DCFS/ARCCC (19%), neighbors/friends (18%), or relatives (9%). Throughout the lifetime of the waiver, a higher percentage of parents reported they learned about the opportunity from neighbors, friends, and relatives and a lower percentage from DCFS/ARCCC.

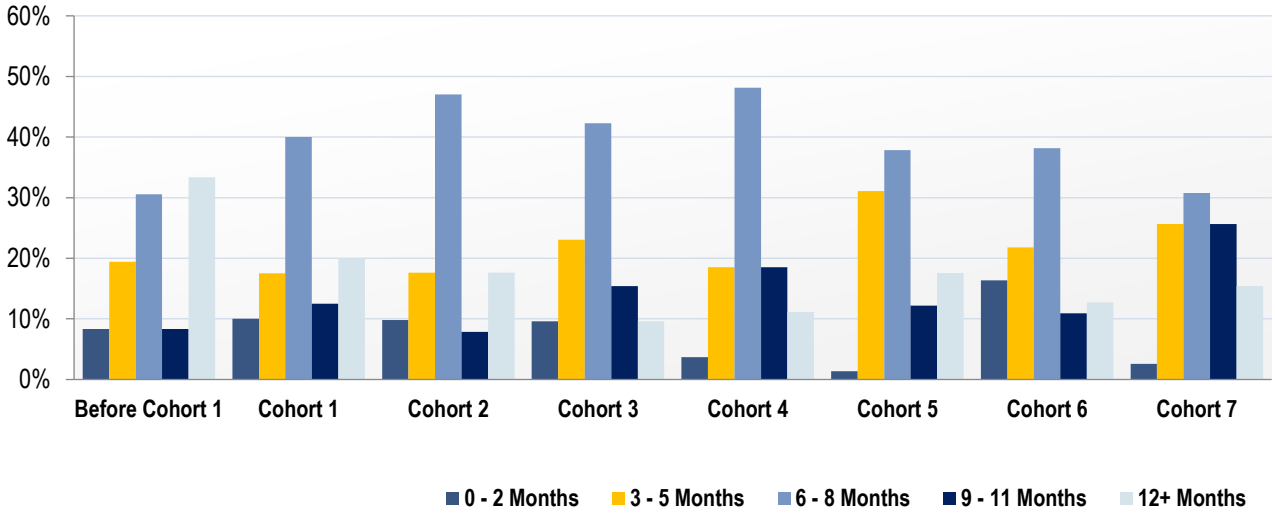
Figure 18. How Families Surveyed Learned About the Opportunity to Foster



Time to Approval

In the survey, families were asked how much time elapsed between when they first inquired about becoming a resource family and when they were approved. As displayed in Figure 19, the average time to approval across all seven cohorts was 6.93 months, a substantial improvement from the six months prior to the Waiver period (8.06 months). It is worth noting, however, that the average time to approval reported during the most recent six months was roughly seven and a half months, the longest reported time to approval of any reporting period.

Figure 19. Time to Approval



Foster Parent Training

The survey of resource families also asked parents which agency provided the required Parent Resources for Information, Development, and Education (PRIDE) training and how helpful they found the training to be in preparing them to welcome foster children into their homes. Among the five training providers, *i.e.*, ABC – Get Connected, Christians for Kids, DCFS, MidSOUTH and The C.A.L.L., The C.A.L.L. trained the highest number of approved families. Regardless of provider, 76 percent of the families surveyed reported the training was either "helpful" or "extremely helpful" in preparing them to become a resource family. Parents receiving training through DCFS reported the lowest level of satisfaction (64 percent), while training through The C.A.L.L. reported the highest degree of satisfaction (82 percent).

Home Preferences

One of the goals of ARCCC was to place children in homes that can meet their needs. Table 29 shows the willingness of homes to accept particular demographics. In general, there has been little change since the program was implemented in the characteristics of children which homes are willing to accept. One exception was that the percentage of homes willing to accept children with any disability has increased by over 10 percentage points since the start of the program; however, the percentage of homes willing to accept children with behavioral disorders is now below eight percent, the lowest percentage of any reporting period.

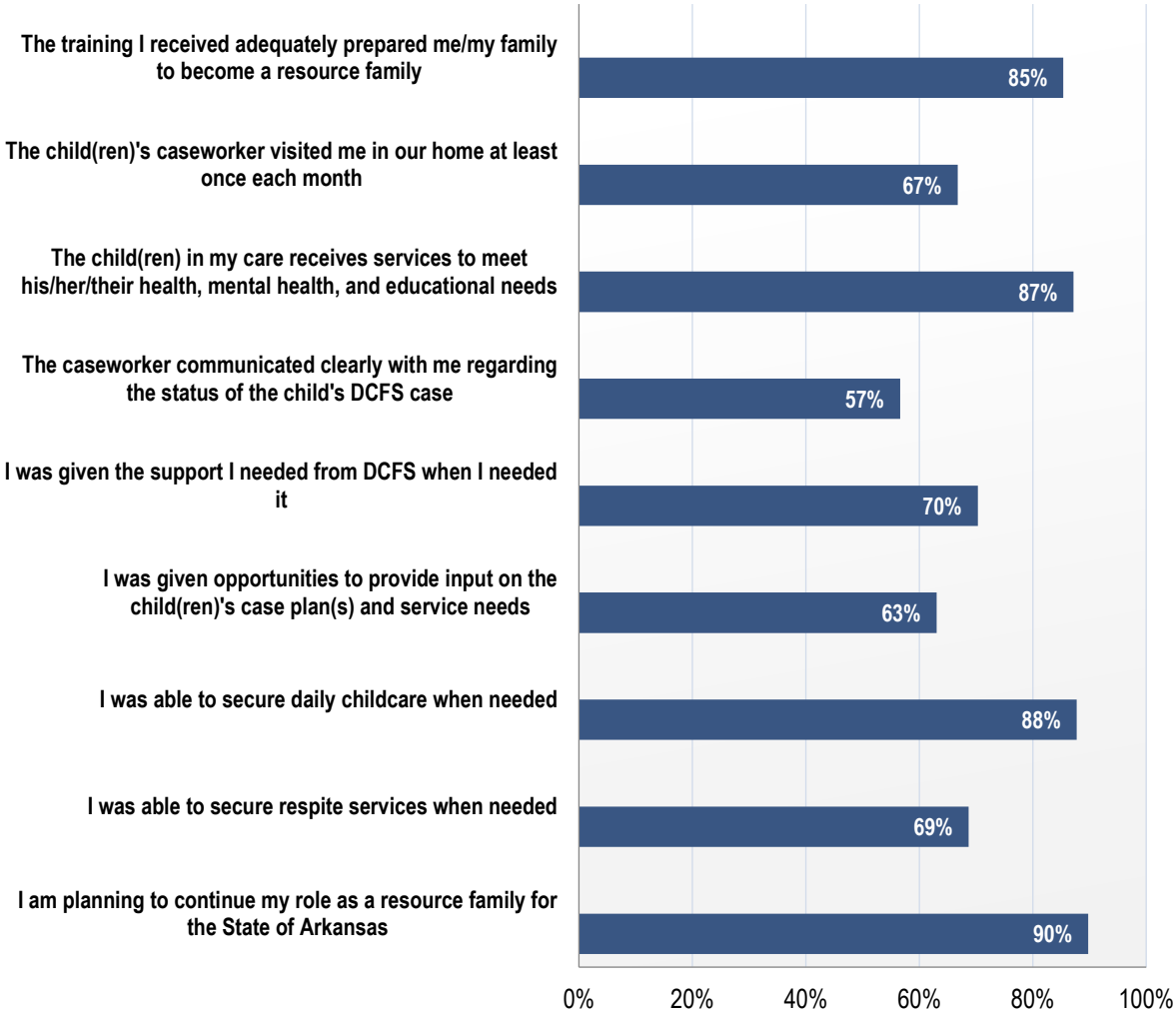
Demographic	Cohort 1	Cohort 2	Cohort 3	Cohort 4	Cohort 5	Cohort 6	Cohort 7
Gender							
Males	74.4%	74.6%	70.9%	72.0%	74.3%	72.3%	68.4%
Females	77.5%	78.3%	78.7%	75.6%	74.7%	74.7%	71.8%
Age							
0 to 10	86.9%	86.8%	87.7%	85.4%	84.2%	84.8%	80.4%
11 to 17	52.3%	51.3%	52.6%	51.7%	49.2%	52.3%	51.6%
Race/Ethnicity							
AI/AN	1.0%	1.2%	1.3%	1.4%	0.8%	0.7%	0.6%
Asian	1.0%	1.1%	1.3%	1.0%	1.0%	0.8%	0.5%
Black	9.5%	12.2%	13.0%	12.1%	12.3%	11.6%	14.2%
NHOPI	0.8%	1.7%	1.2%	0.9%	0.8%	0.6%	0.6%
White	27.5%	25.9%	29.0%	32.1%	29.9%	25.2%	27.2%
Hispanic	0.2%	1.1%	1.4%	1.1%	0.7%	1.0%	1.6%
No Racial Preference	62.0%	61.2%	58.2%	55.7%	57.6%	63.6%	57.8%
Disabilities							
Emotionally Disabled	16.7%	14.3%	13.1%	15.1%	13.5%	12.9%	11.0%
Behavioral Disorders	14.4%	16.9%	14.0%	13.8%	9.5%	9.8%	7.9%
Medical Conditions	7.9%	6.3%	8.3%	9.5%	8.9%	9.9%	7.9%
Any Disability	34.1%	33.1%	36.0%	36.8%	39.1%	43.9%	45.6%
Siblings							
Siblings	98.4%	99.3%	97.1%	98.0%	98.3%	97.8%	98.0%

Table 29. Percentage of Homes Willing to Accept Children in Foster Care

Satisfaction

Through the resource family survey, foster and adoptive parents were given an opportunity to describe their experiences with the application and approval process. Figure 20 shows the extent to which the surveyed families across all cohorts agreed with certain statements concerning the application and approval process. Encouragingly, 85 percent of all respondents indicated the training they received adequately prepared them to become a resource family, and 90 percent reported they planned to continue serving as a resource family for the State of Arkansas; however, only 57 percent of the families surveyed said their caseworker communicated clearly with them regarding the status of the child's DCFS case, indicating a need for better communication between caseworkers and resource families.

Figure 20. Resource Family Engagement



Child Well-being

The case record reviews identified youth with circumstances which may affect permanency, including medically needy children and those with behavioral issues. Data from the reviews were analyzed to determine the extent to which needed services were provided to the youth while in the newly approved ARCCC home, as shown in Table 30. Children commonly received basic physical health services (*e.g.*, check-ups, dental care), with 95 percent of the children receiving these services as needed. Roughly 70 percent of the children who needed educational, special physical health and/or mental/behavioral health supports received those services.

Services	Youth Needing Services	Services Fully Received	Services Somewhat Received	Services Not Received
Basic Physical Health Services	257	244	6	3
Special Physical Health Services	42	31	5	4
Mental/Behavioral Health Services	137	95	20	18
Educational Supports	41	28	8	2

Table 30. Services Provided While in the ARCCC-Approved Home

Discussion

During the Waiver period, the average length of time required for resource families to get from inquiry to approval was 6.93 months, a marked improvement from prior to the implementation of ARCCC (8.06 months).

Among the five PRIDE training providers, The C.A.L.L. trained the highest number of the families who were approved during the Waiver period and earned the highest satisfaction rating. Regardless of provider, about three-quarters of the families surveyed agreed the PRIDE training was beneficial in preparing them to become resource families. Encouragingly, 85 percent of all survey respondents indicated the training they received adequately prepared them to become a resource family, and 90 percent reported they planned to continue serving as a resource family for the State of Arkansas; however, only 57 percent of the families said their caseworker communicated clearly with them regarding the status of their child(ren)'s DCFS case, indicating a need for better communication between caseworkers and resource families.

In general, there has been little change since the program was implemented in the characteristics of children which homes are willing to accept. One exception is that the percentage of homes willing to accept children with any disability has increased by more than 10 percentage points since the start of the program; however, the percentage of homes willing to accept children with behavioral disorders dropped from 14.4 percent to 7.9 percent over the course of the project. Of the children who were placed in ARCCC approved homes and needed basic physical health services (*e.g.*, physician check-ups, dental care), 95 percent received these services as needed. Roughly 70 percent of the children who needed educational, special physical health and/or mental/behavioral health supports received those services.

Outcome Study

Sample

Overall, ARCCC was implemented to improve permanency for children placed in foster care. As a result, the focus of the outcome study is "children." To measure child outcomes, a comparison group was selected for children in care prior to implementation of ARCCC. Results for those children were compared to children placed in an ARCCC approved home. A propensity score was developed using the characteristics of the first child placed into the newly approved home, applying the following variables: home service area, child removal area, age of the child at placement, child's length of time in care, gender, race and ethnicity of the child, and the allegation of the case presented at the time the child became known to DCFS. The comparison group was created among the children placed into a family foster home between August 1, 2013 and January 31, 2015, after the home was first approved.

Propensity scores were found using the nearest-neighbor matching algorithm to select children into the comparison group. Table 31 shows the number of children in the treatment and comparison groups by cohort, allowing for at least six months to have passed since approval of the family to serve as a resource home for a child to be placed in the treatment group home.

Cohort	Treatment	Comparison
Cohort 1 (2/1/2015 – 7/31/2015)	285	285
Cohort 2 (8/1/2015 – 1/31/2016)	359	359
Cohort 3 (2/1/2016 – 7/31/2016)	423	423
Cohort 4 (8/1/2016 – 1/31/2017)	773	773
Cohort 5 (2/1/2017 – 7/31/2017)	815	815
Cohort 6 (8/1/2017 – 1/31/2018)	703	703

Table 31. Number of Children in Treatment and Comparison Groups by Cohort

Data from CHRIS, DCFS' case management system, supplied the evaluation with objective data on children and families, case plans, services, strengths and risks, as well as safety and permanency outcomes. As described above, HZA used a treatment group and a comparison group to measure child welfare outcomes, with the comparison group being constructed using propensity score matching, with a total of 295 case records reviewed across a three-year period. Case records were reviewed using a structured data collection instrument which the reviewers had been trained to use.

Results

Home Outcomes

Approved Homes

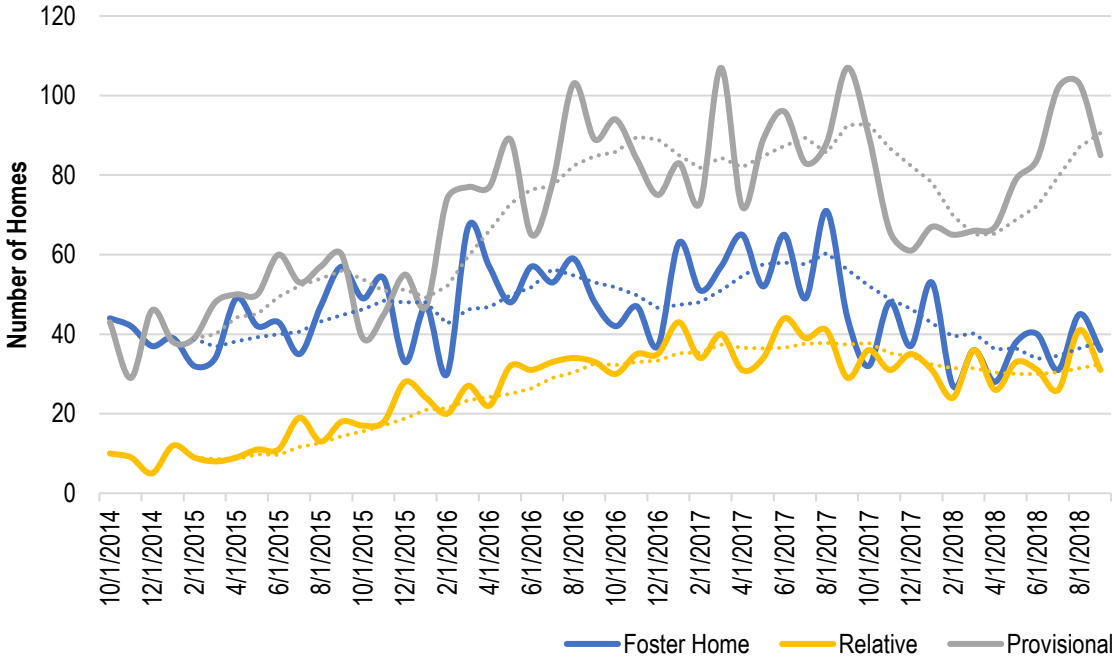
To examine the impact of the initiative in terms of increasing the availability of homes approved to care for Arkansas's foster children, Table 32 shows the number of approved homes within each six-month cohort, broken down by Service Area. The total number of approved homes recruited peaked during Cohort 5 before declining steadily over the final year of the project. Despite the significant drop-off from Cohort 5 to Cohort 7, the total number of approved homes recruited during the final six-month reporting period represents a significant improvement over the first reporting period. Over the course of the evaluation, nine of Arkansas's 10 Service Areas saw an increase in the volume of approved homes, with Area 2 being the lone exception.

Area	Cohort 1	Cohort 2	Cohort 3	Cohort 4	Cohort 5	Cohort 6	Cohort 7
1	97	103	136	135	142	168	140
2	122	108	139	168	192	146	120
3	39	47	78	76	98	87	71
4	33	50	51	59	58	60	43
5	61	87	108	122	104	87	84
6	77	92	106	110	118	116	88
7	41	51	60	72	62	47	64
8	69	77	137	164	184	139	120
9	50	78	91	91	92	95	82
10	29	34	50	50	42	57	46
Total	**618**	**727**	**956**	**1047**	**1092**	**1002**	**858**

Table 32. Approved Homes by Area

To identify what was contributing to the recent decrease in homes, Figure 21 shows the number of homes opened statewide each month by placement type. The timeline begins roughly one year prior to ARCCC. The number of newly opened relative and provisional homes increased dramatically between 2015 and 2017. This is due to a combination of a push by Arkansas to recruit relative homes and a rapid increase in the foster care population. Over the past year, fewer youth entered care and the recruitment of these placement types began to decline.

Figure 21. Number of Homes Opened Each Month

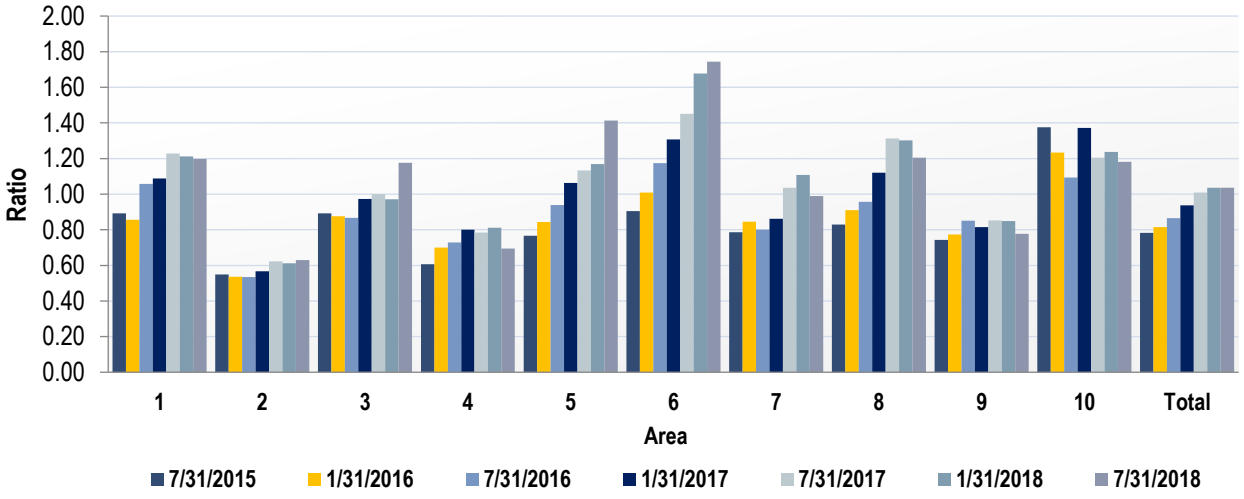


Perhaps the most intriguing feature of Figure 21 is the abrupt decline of newly approved foster homes in September of 2017 which has continued throughout the past year. It is possible this reduction in approved homes is caused by 1) turnover in the Community Engagement Specialist position, who are hired to recruit foster homes; or 2) the recruitment strategies employed by the CESs and community partners (*e.g.*, The C.A.L.L.) having exhausted the population of families willing to become foster homes and the need to develop new strategies to reach a different population.

In an effort to provide an ideal placement location for each youth entering care, there should be multiple foster care beds available for each child. Figure 22[6] shows the bed-to-child ratio for each Area and statewide. As of the end of the Waiver period, statewide there were more beds available than youth in care. In Area 6 (Pulaski County, where Little Rock is located) the ratio is nearly 1.75. Areas 5 and 6 show the largest improvements since the start of the Waiver while Area 10 reports the only decrease in bed-to-child ratio over the same time frame.

[6] Beds shown are inclusive of family foster homes, therapeutic foster homes, relative and fictive kin homes, and private agency homes.

Figure 22. Bed-to-child Ratio



Homes with Placement

Figures 23 and 24 show the percentage of homes with a child placed within one and six months, respectively, following the homes' approval. Statewide, 83 percent of the homes recruited between August 2017 and January 2018 had a placement within one month and 95 percent had a placement within six months. In Area 6, the percentage of homes with a child placed within one month has decreased to roughly 70 percent, though this drop is likely due to the surplus of beds available for the children removed from this Area.

Figure 23. Percentage of Homes with a Child Placed Within One Month

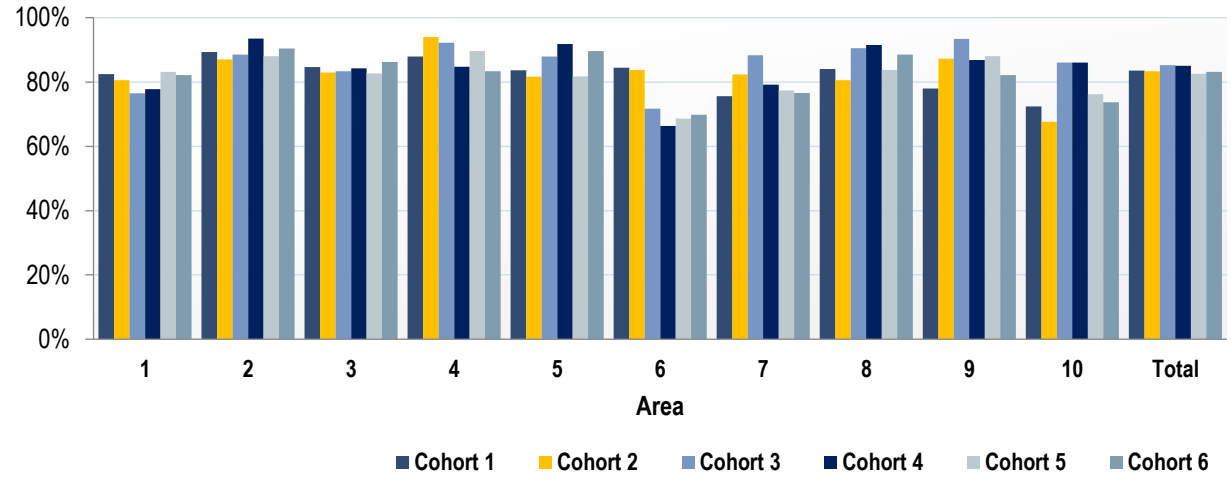
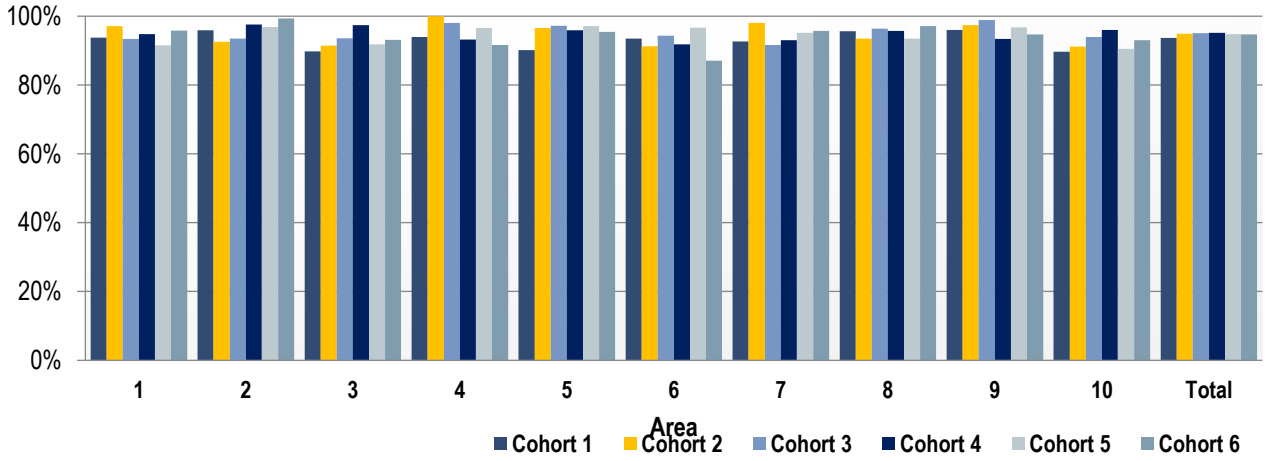


Figure 24. Percentage of Homes with a Child Placed Within Six Months



Child Outcomes

Child Placements

With the increase in foster homes, it was expected that children will be placed in their home communities more frequently. To examine how often children remain close to home, Table 33 displays the percentage of children[7] placed in the same Area from which they were removed. Despite the increased number of beds, children in the treatment group are equally or slightly less likely to be placed in the same Area as are comparison group children. Areas 8 and 9 in particular are less likely to place youth in their removal Area.

Removal Area	Cohort 1		Cohort 2		Cohort 3		Cohort 4		Cohort 5		Cohort 6	
	Tx	Comp	Tx	Comp	Tx	Comp	Tx	Comp	Tx	Comp	Tx	Comp
1	96%	98%	93%	96%	95%	95%	91%	96%	87%	91%	90%	92%
2	71%	70%	67%	58%	71%	61%	78%	78%	83%	86%	75%	73%
3	88%	76%	73%	67%	76%	86%	78%	71%	89%	90%	78%	78%
4	92%	95%	88%	81%	75%	83%	94%	85%	69%	73%	75%	76%
5	92%	78%	89%	94%	88%	77%	73%	86%	80%	83%	82%	80%
6	92%	88%	89%	85%	77%	80%	83%	82%	85%	88%	84%	81%
7	91%	86%	72%	89%	85%	81%	80%	76%	65%	70%	65%	63%
8	84%	93%	77%	90%	82%	93%	83%	92%	86%	93%	87%	93%
9	60%	81%	69%	75%	63%	88%[8]	66%	78%	65%	72%	68%	73%
10	86%	57%	71%	67%	90%	78%	73%	78%	88%	69%	74%	66%
Total	**84%**	**83%**	**80%**	**81%**	**80%**	**83%**	**80%**	**83%**	**80%**	**84%**	**79%**	**79%**

Table 33. Percentage of Children Placed in the Same Area as Removed

[7] The analysis is based on the first child placed into the ARCCC approved home. See the Methodology section for detail on the creation of this group.
[8] Significant at the $p < 0.05$ level

Placement stability remains one of the major goals of the ARCCC program; children who are placed in an ARCCC home should experience fewer placement changes than children in the comparison group. Figure 25 shows the percentage of children with one or no placement changes within three, six and twelve months of placement into the home. Children placed in a home opening between February and July 2016 experienced slightly less placement stability at twelve months with respect to the comparison group, though the results are not significant. In general, children placed in ARCCC approved homes are equally as likely to have stability within three months of placement as children in the comparison group and slightly less likely to have stability at six and twelve months.

Figure 25. Percentage of Children with One or Zero Placement Changes

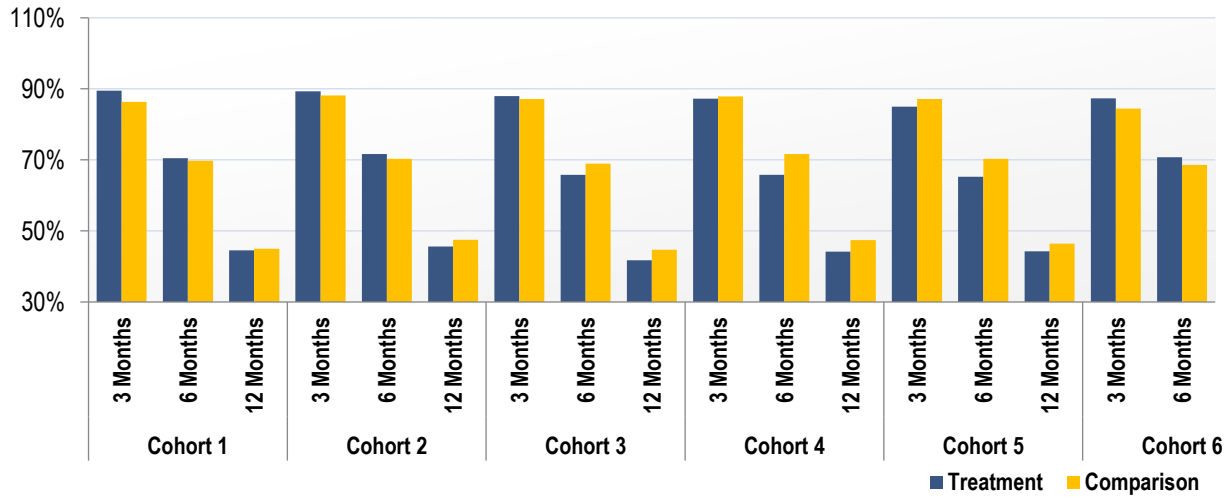


Table 34 shows an analysis of placement stability for children with and without circumstances which can affect permanency. Not surprisingly, children with behavioral issues saw the highest rate of placement change. Only 33 percent of youth with medical issues were moved from their ARCCC placement, which was a significantly smaller percentage than youth with no circumstances affecting permanency.

Circumstance Affecting Permanency[9]	Percentage Moved
Medical (N = 51)	33%
Behavioral (N = 81)	62%
None (N = 232)	44%

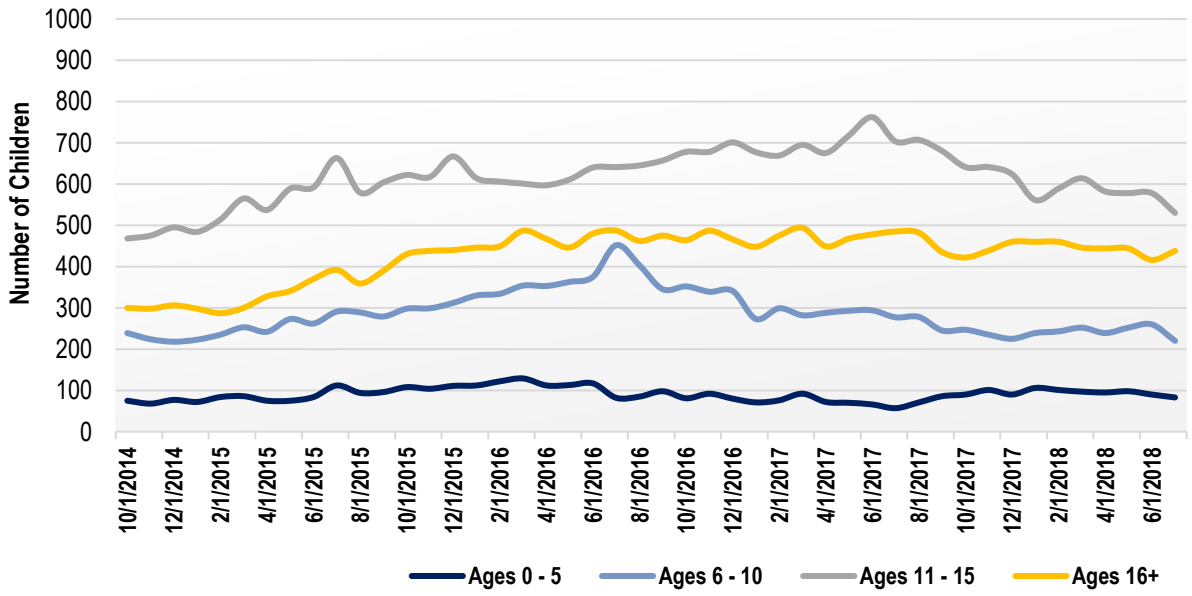
Table 34. Placement Stability for Youth with Circumstances Affecting Permanency

[9] The total N does not add up to the 295 sampled cases since a child may have both a medical and behavioral condition affecting their permanency.

Congregate Care

One of the fundamental goals of the ARCCC program was to reduce the number of children placed in congregate care settings. Ideally, the increase in approved family foster homes should have a positive impact on reducing the size of the congregate care population. The number of youth in congregate care from January 1, 2014 until January 1, 2018, broken down by age, is shown in Figure 26. During the last year of implementation, the total number of youth placed in congregate care has decreased, primarily among youth ages six to fifteen. At present, children ages 11 to 15 account for approximately half of Arkansas's congregate care population.

Figure 26. Number of Children in Congregate Care



Discussion

Over the course of the evaluation, Arkansas's 10 Service Areas saw an increase in the volume of approved resource homes. The number of newly opened relative and provisional homes increased dramatically between 2015 and 2017. Although the number of approved homes declined significantly over the project's final year, the total number of approved homes recruited during the final six-month reporting period represents an improvement over the first reporting period.

Over a three-year period between the end of July 2015 and the end of July 2018, the statewide bed-to-child ratio improved from 0.78 to 1.04, meaning there is at least one bed available statewide for youth in care. As of the end of the most recent reporting period, the highest bed-to-child ratio belongs to Area 6 which has 1.75 beds available for each youth in care.

Statewide, the percentage of homes recruited during the Waiver period which had a child placed within one month of approval remained quite consistent (between 83 and 85 percent) across all reporting periods. The percentage of homes which had a child placed within six months also remained similarly consistent (between 94 and 95 percent). Since ARCCC was first implemented, the percentage of children who were removed from a home and subsequently placed within the same Area declined slightly, from 84 percent during the first six-month reporting period to 79 percent during the most recent reporting period. In general, the percentage of children in the treatment group who were placed within their home Area was slightly lower than the comparison group.

Across all cohorts, children placed in ARCCC homes generally displayed slightly better placement stability at three months than children in the comparison group. At six and twelve months, on the other hand, the comparison group displayed slightly better placement stability than the children in ARCCC homes. The placement stability displayed by ARCCC children at six and twelve months (relative to the comparison group) is concerning given that placement stability remains one of the primary goals of the ARCCC program. Statewide, the number of children placed in congregate care settings increased during the first half of the Waiver period before declining steadily over the past year, especially among children ages six to 15. At present, children ages 11 to 15 account for approximately half of Arkansas's congregate care population.

Not surprisingly, children with behavioral issues saw the highest rate of placement change (*i.e.*, the least stability), with 62 percent of these youth being moved from their ARCCC placement. At the same time, only one-third of youth with medical issues were moved from their ARCCC placement, a significantly smaller percentage than for youth with no known medical or behavioral issues.

Cost Study

Table 35 displays the cost of room and board payments (for those removed from their homes) and service payments for up to twelve months following the initial placement into a newly approved home for both treatment and comparison group members. In general, the average cost per child is cheaper by nearly $400 for ARCCC youth than comparison group children.

As with the cost studies of DR and NFA, the majority of the cost savings comes from reducing the number of nights children spent in substitute care, particularly congregate care. Due to the nature of this initiative, all youth removed spent time in foster care, and treatment group youth spent an average of 11 days less in foster homes than comparison group youth. The percentage of youth entering congregate care is smaller for the treatment group (11 percent) than the comparison group (14 percent). Treatment group youth who enter congregate care, however, spent slightly more nights on average than comparison group youth (11 more nights).

Cohort	Total Number of Children	Total Foster Care Costs	Total Congregate Care Costs	Total Service Costs	Average Cost per Child
Treatment Group					
1	285	$963,885.75	$428,565.26	$7,745.08	$4,912.97
2	359	$1,215,285.49	$524,441.40	$11,402.78	$4,877.80
3	423	$1,452,567.05	$573,302.40	$9,275.90	$4,811.22
4	773	$2,140,305.71	$867,119.88	$40,058.57	$3,942.41
5	815	$2,247,195.93	$1,262,568.24	$46,906.48	$4,364.01
Total	**2,655**	**$8,019,239.93**	**$3,655,997.18**	**$115,388.81**	**$4,440.91**
Comparison Group					
1	285	$930,038.03	$467,111.16	$17,060.13	$4,962.14
2	359	$1,187,553.74	$552,780.78	$25,610.11	$4,919.07
3	423	$1,440,626.26	$652,565.80	$11,848.31	$4,976.45
4	773	$2,416,187.04	$1,325,001.74	$42,520.88	$4,894.84
5	815	$2,460,891.05	$1,252,144.56	$61,774.22	$4,631.67
Total	**2,655**	**$8,435,296.12**	**$4,249,604.04**	**$158,813.65**	**$4,837.56**

Table 35. Maintenance and Service Costs for ARCCC

Permanency Round Tables

Permanency Roundtables (PRTs) were intended to support permanency planning and improve outcomes for youth who have been in foster care for 18 months or longer. The PRTs were designed to engage a youth's caseworker, supervisor, a permanency consultant, and other case-specific stakeholders to address what is needed to help youth achieve permanency. Key stakeholders are engaged to develop a permanency plan that can be implemented over the following six months, while program leads are encouraged to identify and address barriers to permanency through professional development, policy change, resource development and engagement of system partners. The PRT model, developed by Casey Family Programs, employs a set agenda for the meetings and each meeting is to result in a Permanency Action Plan and Permanency Action steps for case stakeholders to complete.

Permanency Roundtables are intended to support permanency planning for youth who have been in foster care 18 months or longer. The youth involved in the case also participates in the meeting when DCFS staff deem his or her involvement appropriate. Beyond measuring the extent to which PRTs were conducted for youth who have been in care for longer periods of time, it is also important to assess the extent to which youth were engaged in the process. Youth who have a voice in their service planning are more likely to succeed than those who do not.

Due to the lack of positive outcomes, inconsistent implementation, and limited fidelity to the model, PRTs were discontinued after August 2016.

Process Study

Sample

Case reviews were conducted to determine the extent to which processes were carried out as intended under the PRT model. The reviews were also used to measure the extent to which youth were engaged. Table 36 shows the number of cases in each case review period as well as the distribution of reviews by area. It is possible that the same youth received multiple PRTs and each instance of the intervention was reviewed.

Interviews were also conducted to solicit staff feedback on the PRT process and implementation. Interviews were conducted, with approximately 10 to 20 interviews occurring annually; these were randomly selected across Service Areas, with one county selected in each Service Area from which to collect data.

Area	August 2013 – January 2015		February 2015 – January 2016	
	N	%	N	%
1	2	3%	14	15%
2	23	30%	22	23%
3	6	8%	1	1%
4	3	4%	0	0%
5	17	22%	8	8%
6	10	13%	24	25%
7	6	8%	7	7%
8	10	13%	8	8%
9	1	1%	5	5%
10	0	0%	7	7%
Total	**78**	**100%**	**96**	**100%**

Table 36. PRTs by Service Area and Cohort (Case Reviews)

Results

Initiative Rollout and Implementation

PRTs were conducted prior to the start of the Waiver period and were revitalized when the Waiver was implemented. To prepare for implementation under the Waiver, conference calls and meetings were held with consultants and/or staff from other states who had experience with PRTs. When interviewed, the majority of staff did not recall whether DCFS assessed their counties' readiness to implement Permanency Roundtables, although a few staff did recall that DCFS looked at reports of children who have been in care the longest without a permanency plan.

Training was the primary activity conducted to prepare staff for implementation of PRTs under the Waiver. The Annie E. Casey Foundation provided the original PRT training which was provided prior to the start of the initiative under the Waiver. Follow-up training was also provided in several counties after the start of the Waiver. While the two- to three-day initial training was reported to be helpful for staff, caseworkers had mixed reviews about the follow-up training they received. Several staff found the follow-up training to be informative, providing details on how the PRTs should be conducted, while others reported that training was not extensive enough or helpful.

Participation

Between August 1, 2013 and July 31, 2016, a PRT was completed for 227 youth. Table 37 shows the demographics of the youth at the time of the first PRT. Implementation of the model was more successful in some Areas than others. Referring to case record reviews which were used to measure fidelity, Permanency Roundtables were inconsistently implemented across the state. In the first 18 months of the initiative, four counties (Benton, Crawford, Pulaski and Sebastian) accounted for 40 percent of the PRTs. The majority of youth were ten or older and had been in foster care for at least two years.

Demographic	Tx 1	Tx 2	Tx 3	Tx 4	Tx 5	Tx 6
Number of Children	47	17	55	55	22	31
Service Area						
Area 1	0%	0%	5%	18%	0%	23%
Area 2	28%	0%	15%	18%	27%	26%
Area 3	13%	0%	20%	2%	0%	0%
Area 4	2%	0%	5%	0%	0%	0%
Area 5	0%	100%	0%	9%	0%	26%
Area 6	28%	0%	24%	29%	18%	0%
Area 7	0%	0%	7%	9%	9%	3%
Area 8	19%	0%	0%	0%	32%	6%
Area 9	11%	0%	13%	2%	14%	13%
Area 10	0%	0%	11%	13%	0%	3%
Gender						
Male	55%	71%	58%	60%	45%	61%
Female	45%	29%	42%	40%	55%	39%
Race/Ethnicity						
Black	30%	0%	31%	38%	32%	16%
White	60%	88%	56%	51%	45%	71%
Other	11%	12%	13%	11%	23%	13%
Hispanic (Ethnicity)	2%	0%	15%	4%	0%	0%
Age						
Age 0–4	9%	0%	2%	16%	5%	3%
Age 5–9	23%	6%	13%	13%	0%	23%
Age 10–14	30%	29%	44%	24%	45%	42%
Age 15–17	32%	59%	38%	36%	45%	26%
Age 18+	6%	6%	4%	11%	5%	6%
Length of Time in Care						
In Care < 19 Months	30%	18%	9%	40%	9%	35%
19–23 Months	6%	18%	13%	7%	23%	26%
24–29 Months	0%	0%	22%	13%	18%	0%
30–35 Months	13%	0%	9%	5%	9%	6%
In Care 36+ Months	51%	65%	47%	35%	41%	32%

Table 37. Demographics of PRT Youth

Process Fidelity

As noted earlier, the PRT model is intended for youth who have been in care 18 months or longer. The case record reviews found that nearly three-quarters of the youth who received an initial PRT between August 2013 and January 2016 were in foster care for more than 24 months at the time of the initial PRT. Another 12 percent had been in care 18 to 24 months across the two review periods.

Generally, youth who remain in care for longer periods of time have or encounter issues which make it difficult for them to achieve permanency. Youth who receive PRTs may have special circumstances such as behavioral, medical, court or cultural issues that could make securing a permanent placement and identifying lasting connections challenging. Results of the case review analysis found that close to half of the youth (49 percent) who received a PRT have behavioral issues (*e.g.*, aggressive behavior or rule breaking) and 13 percent required a medically capable home. Only two youth had circumstances involving court orders (*e.g.*, cannot be placed with younger siblings/other children) or cultural requests (*e.g.*, Spanish-speaking home).

At each PRT meeting, the Child Permanency Rating Chart is to be completed to record the youth's permanency status at the time of the PRT. Permanency status is recorded using a scale of poor, marginal, fair, good, very good and permanency achieved. A rating of poor represents youth living in a temporary placement without a clear permanency plan; permanency achieved, at the other end of the spectrum, represents youth who have achieved legal permanency after having been in custody for a relatively long period of time. Close to a third (32 percent) of the youth who received a PRT received a permanency rating of good or marginal while the balance received a rating of fair or poor. It is not expected that youth would have a higher rating (*i.e.*, very good) on the Child Permanency Rating Chart because all youth who receive a PRT have been in care for at least 18 months, without having achieved permanency. However, this tool is designed to be used on an ongoing basis to measure improvement in youth achieving the ultimate goal of permanency.

Best practice guidelines for Permanency Roundtables require that specific topics be discussed and documented. Case review data show the frequency with which key topics, including placement history, relative placement, youth support systems, service needs and legal information, were discussed at the PRT meetings. In 50 percent of the cases, the youth's placement history was brought up in whole or part, and current placement was discussed in 61 percent of the cases. The youth's support system was discussed in 52 percent of the cases, legal information was discussed in 68 percent of the cases, and the youth's needs and services were examined in 69 percent of the cases. Permanency planning and permanency resources were noted in two-thirds of the cases. These findings suggest that important topics that should be integrated into all PRTs and Action Plans were not consistently discussed or addressed.

A critical element of the PRT is development of an Action Plan for each PRT participant. The Action Plan is intended to be a realistic plan for achieving or obtaining permanent connections for the youth. Based on the case review findings, PRTs in Arkansas consistently focused on searching for permanent placements and connections for the youth. For both case review cohorts, Lexus Nexus searches were the most common action to be accomplished which caseworkers are to complete.

Action	August 2013 to January 2015 N=78	February 2015 to January 2016 N=96
Adoption Services	38%	12%
Counseling Services	2%	1%
DDS Services	7%	2%
Engage Youth in Permanency Discussion	14%	5%
Explore Educational Services	9%	3%
Explore Guardianship	40%	13%
Explore Transitional Services	7%	2%
Family/Life-Long Connections	2%	1%
Fetal Alcohol Syndrome Assessment	11%	4%
Locate Paternal/Maternal Family	30%	10%
Lexus Nexus Search	49%	46%
Locate Biological Parents Mom/Dad	3%	5%
Medical/Psychological Evaluation	9%	3%
Mentoring	18%	16%
Other	12%	9%
Placement (TFC/Foster Care)	51%	8%
Sibling Connections	9%	16%
Transitional Team Meeting	3%	38%
Total	14%	3%

Table 38. Case Reviews: Action Plans by Cohort (Percentages)

Caseworkers were asked to document the last time they talked to the youth about their permanency options as they prepare for the PRT meeting. When comparing the results from the cases reviews conducted of PRTs that took place during the first 18 months of the initiative and the twelve months that followed, the percentage of youth whose caseworker discussed permanency options with them increased from 13 percent to 45 percent (as seen in Table 38). The percentage of cases in which those discussions happened within two to three months of the PRT also increased, going from four to 17 percent between the two time periods.

Even when permanency cannot be achieved, one goal of the PRT is to find youth a permanent connection with someone who will provide a lasting meaningful relationship. A permanency connection with at least one adult had been made with 21 percent of youth for whom a PRT was completed. A connection was not made for over half of the youth; however, the percent of youth for whom a connection had not been made decreased for youth whose PRT meetings took place between February 2015 and January 2016 (34%) from those whose meetings happened between August 2013 and January 2015 (75%).

Follow-up is a key component of the PRT process and an important element for youth in achieving permanency. Action plans are expected to be completed within three to six months of the PRT meeting. Overall, 310 Action Plans were created for youth who received a PRT between August 2013 and January 2015, while youth whose PRT was held in the twelve months that followed had 234 Action Plans created. For both cohort periods, nearly half of all Action Plans had limited to no progress (46 percent) than Plans that had Action Initiated (56 percent).

Overall, staff reactions on the effectiveness of the PRT initiative were mixed. While some staff found PRTs to be helpful, primarily because of the sharing of information among key stakeholders, others did not find them to be effective. Some staff reported that PRTs provided caseworkers with an opportunity to look at the strengths of the youth, since these are youth for whom it is usually more difficult to develop a plan. Others suggest little to none of the Permanency Action Plans were completed within six months of the PRT, falling short of achieving permanency for youth within that same time frame.

In interviews with staff, a few noted issues with judges and attorneys being resistant to the process. Staff voiced frustration because at times the PRT participants came up with options for the youth, only to have the judges or attorneys reject them. According to staff, when this happens, permanency options that were originally on the table ceased to be pursued. However, there were other staff who reported that some judges became more open to permanency options resulting from the Permanency Roundtables.

Most counties report that existing staff were used to complete the responsibilities associated with the PRTs. This was noted as a challenge because PRTs are time consuming. With caseworkers continuing to have the same caseloads, they have higher burdens of work when PRTs are taking place. Caseworkers and supervisors report that even though they spend a lot of time preparing for and hosting a PRT, there is often minimal follow-up or accountability to carry out the Action Plan by stakeholders. Staff also indicate that travel to participate in a PRT can be difficult, so alternative methods to participate, such as videoconferencing, were suggested. Additionally, many PRTs are attended by the State PRT Coordinator, which adds another dimension of added difficulty in getting the meetings scheduled.

Discussion

Permanency Roundtables were not held for as many as children as they should have been, primarily due to the time-consuming nature to prepare and participate in the meetings. Many caseworkers did not find them to be positive in helping youth to achieve permanency. Consequently, youth who might benefit from a PRT were not necessarily having one completed when needed. Another concern voiced by staff involved the training. Gaps in time between when staff were trained and when a youth was identified for a PRT was evidenced; by not actively using the skills or completing the activities for a PRT soon after the training, the gap in time caused a lapse in retaining what was learned and thus being able to complete the meetings and their activities as intended. Although staff agree that PRTs are important for permanency planning and placement decisions,

staff (both new and experienced) will need training if the meetings were to be used again. Staff suggested the training should incorporate real examples of PRT successes and clarification on guidelines on how to document the process and follow-up actions after the Permanency Action Plan has been developed.

Outcome Study

Key Outcomes

The primary objective of Permanency Roundtables is to achieve permanency for youth, doing so within six months of the PRT meeting.

Comparison/Cohorts

Propensity score matching was not used for this initiative given the variation of the characteristics of youth within the treatment group to what had been expected, *e.g.*, having a PRT completed upon reaching the 18th month in foster care, with a large number receiving the PRT well after their 18th month in care and others sooner. The comparison group is made up of 839 youth who reached 18 months in foster care between August 2012 and July 2013 (*i.e.*, the year prior to implementation). The table below describes the time frames and count of youth for which outcomes were measured using data within CHRIS.

Time frame	Case Review Time frames	Number of Cases
Comparison	August 1, 2012 – July 31, 2013	839
Cohort 1	August 1, 2013 – January 31, 2014	49
Cohort 2	February 1, 2014 – July 31, 2014	18
Cohort 3	August 1, 2014 – January 31, 2015	65
Cohort 4	February 1, 2015 – July 31, 2015	61
Cohort 5	August 1, 2015 – January 31, 2016	24
Cohort 6	February 1, 2016 – July 31, 2016	36

Table 39. PRT CHRIS Time Frames

Sample

The primary objective of Permanency Roundtables is to achieve permanency for youth, doing so within six months of the PRT meeting. Table 40 displays the permanency goals of youth in both the comparison and treatment groups. In each group, a higher percentage of youth had a goal of adoption.

Permanency Goal	Comparison PRT		Experimental PRT	
	N = 839	%	N=253	%
Adoption	383	46%	144	57%
APPLA	93	11%	66	26%
Guardianship	21	3%	2	1%
Permanency Goal Not Yet Established	4	0%	0	0%
Placement with Relatives or Fictive Kin	25	3%	3	1%
Reunification with Parent or Caregiver	313	37%	38	15%

Table 40. Number and Percentage of Youth by Permanency Goal

Over half of the youth within each of the treatment groups had both parents' parental rights terminated as of the time the PRT was conducted. It appears concerted efforts must be made to find adoptive families and those willing to accept guardianship of the youth. While the case reviews did indicate such efforts are being made, there was a decrease in these two items being action steps from that of the first set of case reviews completed to those of the second (Table 41).

TPR Status	Cohort 1 (N = 48)	Cohort 2 (N = 17)	Cohort 3 (N = 55)	Cohort 4 (N = 55)	Cohort 5 (N = 22)	Cohort 6 (N = 31)
TPR on Two Parents	51%	65%	64%	42%	50%	61%
TPR on One Parent	15%	12%	2%	11%	9%	0%
No TRP	13%	24%	35%	47%	41%	39%
Unknown	21%	0%	0%	0%	0%	0%

Table 41. Percentage of Youth by TPR Status at Time of PRT

Results

Permanency

As noted above, the goal of the initiative is help youth who have been in foster care for longer periods of time achieve permanency, either by reunifying them with their families or by discharging them to alternative permanency options. By the same token, it was hoped that use of PRTs would reduce the percentage of children who aged out of care as well as reduce their average length of time in care.

Table 42 shows the majority of children who received a PRT were in still in care six and twelve months following the PRT. The most common reason youth were discharged from foster care at both six and twelve months is due to aging out[10] followed by adoption. While there is evidence some improvement was made in reducing the percentage of children who aged out and an increased rate of adoption following the PRT, there was no evidence that PRTs increased reunification with biological parents or relatives.

[10] Data for aging out includes children who were emancipated.

Time Frame	Reunification	Relative / Fictive Kin	Adoptions	Guardianship	Aging Out	Total
Within Six Months of PRT						
Cohort 1 (N = 48)	4%	2%	2%	0%	0%	8%
Cohort 2 (N = 17)	0%	0%	0%	0%	17%	17%
Cohort 3 (N = 55)	0%	3%	0%	0%	5%	8%
Cohort 4 (N = 55)	7%	3%	2%	0%	5%	16%
Cohort 5 (N = 22)	0%	0%	0%	0%	8%	8%
Cohort 6 (N=31)	0%	0%	0%	0%	3%	3%
Within Twelve Months of PRT						
Cohort 1 (N = 48)	4%	2%	10%	0%	2%	18%
Cohort 2 (N = 17)	0%	0%	6%	0%	28%	33%
Cohort 3 (N = 55)	2%	3%	0%	0%	11%	15%
Cohort 4 (N = 55)	7%	7%	7%	0%	5%	25%
Cohort 5 (N = 22)	0%	0%	4%	0%	8%	13%
Cohort 6 (N=31)	0%	3%	11%	0%	8%	22%

Table 42. CHRIS: Discharge Reasons Within Six and Twelve Months of PRT

For those who achieved permanency in the form of reunification, custody with relative/fictive kin, adoption, or guardianship, Table 43 looks at how quickly that permanency was achieved. With the exception of Cohort 2, the majority of those receiving permanency after a PRT did so within 24 months of the intervention. In fact, the average length of time from PRT to permanency (for those who achieve it) is 17.7 months.

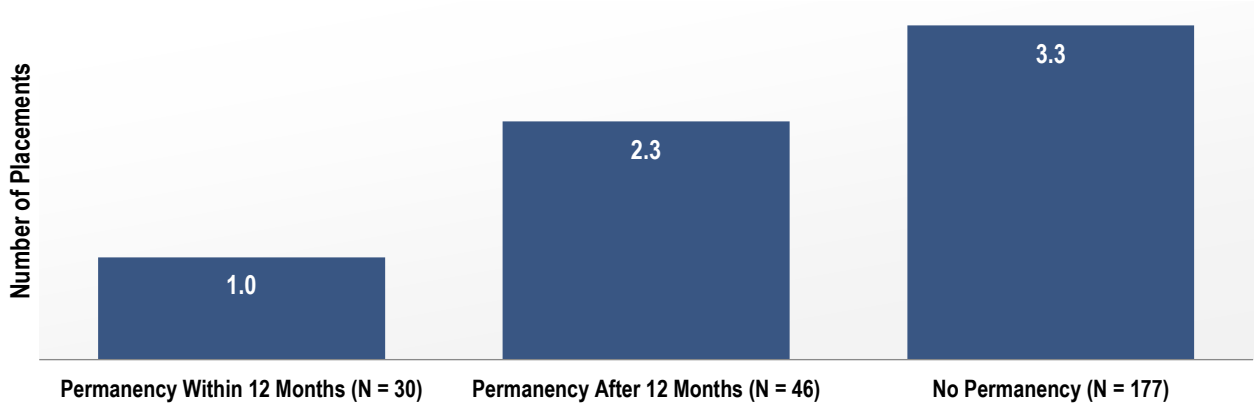
Cohort	Permanency Achieved			Average Number of Months from PRT to Permanency
	Within 12 Months	Between 12 and 23 Months	After 24 Months	
Cohort 1 (N = 48)	16%	12%	12%	19.8
Cohort 2 (N = 17)	6%	6%	22%	29.5
Cohort 3 (N = 55)	5%	11%	6%	20.2
Cohort 4 (N = 55)	20%	10%	3%	11.4
Cohort 5 (N = 22)	4%	13%	8%	19.3
Cohort 6 (N=31)	14%	11%	3%	14.5
Total (N = 227)	**12%**	**11%**	**8%**	**17.7**

Table 43. Timeliness to Permanency After PRT

Placement Stability

After a PRT, it would also be hoped that placements become more stable given the increased direction of the case. Figure 27 shows the average number of placements youth have within twelve months of the PRT. For youth who achieve permanency within twelve months, there is an average of just one placement change compared to nearly 2.5 placements when permanency is achieved after twelve months and over three placements when no permanency is achieved.

Figure 27. Average Number of Placement Changes Within 12 Months of PRT



Discussion

PRTs are designed to help youth achieve permanency or a stable placement, however, as evidenced above, the initiative fell short of these goals. Overall, less than ten percent of youth receiving PRTs found permanency in the form of reunification with biological parents or discharge to relative custody, adoption, or guardianship within twelve months of the roundtable. For those who were able to achieve permanency, it took an average of 17.7 months (nearly a year-and-a-half) after the PRT to finalize the placement. For those not achieving permanency, youth had an average of 3.3 placements within twelve months following the PRT. Due to the limited impact of PRT on finding permanency for youth, the initiative was discontinued in August 2016.

Cost Study

The cost for room and board for foster and congregate care as well as service costs for the year following the initial PRT are shown in Table 44 for the treatment and comparison groups. While there are considerably more comparison group members than treatment group members, thus likely driving down the average cost per child, the overall cost difference between treatment group and comparison group is $13,000 more per treatment group child. Surprisingly, the total congregate care costs for both groups are roughly the same, despite the comparison group having over 600 more youth. Closer inspection reveals that 178 comparison group youth were in congregate care the year after their 18th month in substitute care compared to 148 treatment group youth, yielding an average length of stay in congregate care of over 30 days (244 vs 213, respectively) between treatment and comparison groups.

Cohort	Total Number of Children	Total Foster Care Costs	Total Congregate Care Costs	Total Service Costs	Average Cost per Child
Comparison	839	$1,698,221.72	$4,120,502.42	$25,740.61	$6,965.99
1	47	$117,230.86	$646,051.00	$3,030.72	$16,304.52
2	17	$15,778.44	$422,701.94	$2,683.38	$25,950.81
3	55	$104,124.05	$1,103,932.86	$13,541.44	$22,210.88
4	55	$93,701.08	$774,175.40	$5,419.60	$15,878.11
5	22	$39,090.97	$487,741.36	$400.00	$23,965.11
6	31	$69,226.27	$483,615.32	$362.54	$17,845.29
Total	**227**	**$439,151.67**	**$3,918,217.88**	**$25,437.68**	**$19,307.52**

Table 44. Maintenance and Service Costs for PRT

CANS/FAST

The Child and Adolescent Needs and Strengths and Family Advocacy Support Tool are assessment tools administered to children and adolescents in foster care and families receiving in-home services, respectively. As noted earlier, the CANS/FAST tools replaced the Family Strengths, Needs, and Risk Assessment tool which DCFS had used in the past to help identify children's and families' service needs. The CANS/FAST assessment tools are used as a communication tool for members of child welfare systems to understand and accurately represent the strengths, service needs and interests of children and families.

Several life functioning domains are present in the CANS tool, such as the child's strengths, cognitive, social and emotional/behavioral functioning, and physical health and well-being, while the FAST captures information about the family as a unit, such as collaboration, conflict and resources, caregiver capacity and advocacy, as well as the status of the youth within the household. These domains function to help caseworkers and supervisors accurately score the assessments and determine the best level of action and services necessary for the children/families. Due to the complexity of scoring the tools, including cultural and development considerations which are to be factored in the score, staff must be certified and receive annual recertification to use the tools.

CANS/FAST assessments are administered at the time the case is opened, every 90 days thereafter, and at discharge. Needs in the assessment are organized by domain and are scored to be either actionable or non-actionable.

Process Study

Sample

A total of 376 CANS/FAST cases were selected for case review from a random sample of initial CANS/FAST assessments completed between August 1, 2014 and January 31, 2018. Questions focused around whether assessment items should or should not have been marked as actionable based on information in the case plan, if assessment items should have a comment, and if the services offered aligned with the assessment's identified needs and strengths.

HZA annually spoke with between 20 and 40 stakeholders, inclusive of area directors, county supervisors, and family service workers about the CANS/FAST assessments. Interviews consisted of questions detailing ongoing implementation, training, and successes and challenges of the program.

Results

Planning

Organizational/Area Readiness

DCFS formed a statewide planning workgroup which met monthly to spearhead the integration of the CANS/FAST initiative. The initiative was first implemented in two counties (Miller and Pulaski) in November 2014 and has been in use statewide since February 2015. Staff who participated in the monthly workgroup (mostly staff from implementation counties) worked with Dr. John S. Lyons to determine which questions to include in the CANS/FAST tools to fit with Arkansas's child welfare system, and how staff would be trained.

In addition, Area Directors and Supervisors developed fliers, talked to stakeholders, and discussed the documentation requirements associated with the tools to help staff prepare to implement the assessments into case practice. Since implementation, the CANS/FAST workgroup, in partnership with the intervention's former lead (Brooke Harris), has created several user guides to help staff complete the CANS/FAST tools. These include: a) supervision tips; b) a family engagement tool; c) communication tips for workers using FAST; d) guiding questions for workers to use with families; e) steps for completing CANS/FAST; f) steps for developing case plans; and g) CANS/FAST practice guides.

Training

Prior to implementation, CANS/FAST training was offered to all DCFS staff statewide. The initial full-day of training was conducted by Dr. Lyons and described by staff as informative. Staff also receive refresher trainings from either the Central Office Program Manager or staff from MidSOUTH. In addition to formal trainings, staff practice using the CANS/FAST tools on open cases and then compare scores with each other via conference calls. These coaching calls, which occur every three months with Central Office Staff, have been beneficial for staff who experience challenges with scoring the assessments.

Although staff acknowledge that CANS/FAST trainings have been helpful, they have also articulated that ongoing use of the tools is the most effective way to become comfortable with the assessment tools. Nearly three-fourths of the staff interviewed in the last year reported the training was adequate; they have also indicated improvements could be made to the training. One worker stated the training is "too bare bones; the best [part] was hands on and watching someone enter [the information] into CANS."

Child/Family Demographics

Table 45 displays the total number of youth receiving their first CANS in each six-month cohort beginning in February 2014, along with their demographics. A larger number of CANS were completed in the first year of the initiative compared to the following years, as CANS was completed for youth already in foster care as well as those removed during the year. Nearly all youth with an initial CANS received a follow-up within six-months. There was a large decrease of completed initial CANS in the last six months of implementation due to the decreasing foster care population. Area 2 had the highest percentage of youth first receiving a CANS in all but the last cohort, implying a smaller percentage of youth were removed in this Service Area between February 2018 and July 2018. Nearly half of all youth receiving their initial CANS are under five years old.

Demographic	Tx 1	Tx 2	Tx 3	Tx 4	Tx 5	Tx 6	Tx 7
Number of Children	3,192	2,009	1,837	1,663	1,556	1,449	1,112
Service Area							
Area 1	9%	12%	10%	11%	12%	15%	15%
Area 2	17%	18%	22%	22%	22%	18%	13%
Area 3	7%	6%	9%	7%	7%	8%	5%
Area 4	7%	7%	6%	6%	6%	8%	6%
Area 5	12%	10%	11%	9%	10%	10%	9%
Area 6	13%	11%	7%	8%	7%	6%	5%
Area 7	7%	5%	6%	6%	6%	7%	9%
Area 8	12%	12%	13%	15%	15%	11%	15%
Area 9	13%	15%	11%	11%	12%	12%	18%
Area 10	3%	4%	5%	4%	4%	5%	5%
Gender							
Male	52%	49%	51%	51%	52%	50%	49%
Female	48%	51%	49%	49%	48%	50%	51%
Race/Ethnicity							
Black	17%	20%	15%	17%	15%	17%	18%
White	68%	67%	72%	72%	70%	74%	69%
Other	14%	12%	13%	11%	14%	9%	12%
Hispanic (Ethnicity)	6%	7%	6%	4%	5%	8%	6%
Age							
Age 0–4	40%	44%	46%	47%	51%	50%	50%
Age 5–9	24%	23%	27%	25%	23%	22%	21%
Age 10–14	18%	20%	17%	18%	18%	18%	19%
Age 15–17	14%	11%	9%	9%	9%	10%	10%
Age 18+	4%	2%	0%	0%	0%	0%	0%
Length of Time in Care							
In Care < 19 Months	54%	79%	97%	97%	99%	100%	99%
19–23 Months	13%	6%	0%	1%	1%	0%	1%
24–29 Months	17%	8%	2%	0%	0%	0%	0%
30–35 Months	7%	2%	1%	0%	0%	0%	0%
In Care 36+ Months	10%	5%	1%	0%	0%	0%	0%

Table 45. Demographic Information for CANS Youth

Similar to the above Table, Table 46 shows the number of families and children receiving a FAST in a six-month cohort starting in February 2014 and the associated demographic information. The demographics displayed below are also representative of the families and children with a newly opened in-home case. Initial FAST assessments are conducted with roughly even distribution across the state. There was a large jump in the number of assessments in Area 1 in the third cohort (*i.e.*, February 2015), which corresponds to a sudden jump in the number of in home cases in this Area. Children receiving the FAST are predominantly white (roughly 70 percent) and well distributed in age, though there was a higher percentage of children under five receiving the assessment than the other age breakouts.

Demographic	Tx 1	Tx 2	Tx 3	Tx 4	Tx 5	Tx 6	Tx 7
Number of Cases	2,159	2,127	2,169	1,744	1,973	1,885	1,898
Number of Children	4,840	4,716	4,888	3,988	4,475	4,307	4,338
Service Area							
Area 1	11%	12%	24%	16%	18%	13%	13%
Area 2	13%	11%	10%	11%	14%	13%	13%
Area 3	7%	11%	8%	10%	8%	10%	9%
Area 4	9%	5%	4%	6%	6%	7%	7%
Area 5	16%	12%	13%	10%	11%	13%	12%
Area 6	10%	9%	8%	12%	9%	9%	9%
Area 7	5%	7%	5%	5%	6%	4%	7%
Area 8	11%	12%	10%	12%	12%	14%	15%
Area 9	13%	15%	12%	11%	12%	10%	12%
Area 10	4%	5%	6%	6%	4%	5%	3%
Gender							
Male	48%	51%	51%	50%	51%	52%	52%
Female	52%	49%	49%	50%	49%	49%	48%
Race/Ethnicity							
Black	23%	22%	20%	21%	24%	19%	23%
White	68%	68%	71%	70%	68%	71%	69%
Other	9%	9%	9%	8%	8%	10%	8%
Hispanic (Ethnicity)	6%	6%	9%	7%	6%	7%	7%
Age							
Age 0–4	37%	36%	35%	39%	38%	39%	40%
Age 5–9	29%	30%	30%	27%	26%	27%	27%
Age 10–14	24%	22%	23%	22%	23%	22%	23%
Age 15–17	10%	11%	11%	11%	11%	11%	9%
Age 18+	0%	1%	1%	1%	1%	0%	0%

Table 46. Demographic Information for FAST Families and Youth

Agency Perspective

Interviewed caseworkers report it takes between 30 minutes and 2 hours to enter an assessment into CHRIS. Even half an hour is viewed as too long by most caseworkers, supervisors, and area directors. Additionally, these stakeholders report the assessment is too difficult for new workers to implement with fidelity, which is especially an issue with the high turnover rate for caseworkers.

A number of other issues were raised during the interviews. Several staff reported the assessment was "cut and dry," and the assessments were not personalized. Two supervisors reported the FSNRA did a better job of assessing the families and building case plans. Several staff reported the assessments took away from their interaction with families, the questions were subjective, and the assessment should follow the natural flow of conversation.

CANS/FAST Accuracy

To assess the accuracy of caseworkers scoring each of the assessment's domains, case reviews were conducted to identify if caseworkers scored items as actionable which were not, and conversely, scored items as not being actionable which should have been, based on information in the case file. Table 47 shows the percentage of items in a domain which should /should not have been marked as actionable and if there were comments missing for an item in a particular domain. In the CANS 0–4 assessments, the caregiver substance use needs as well as the strengths domain contained the largest percentage of items which should or should not have been marked.

For youth over five receiving a CANS, the child behavioral health/emotional needs and strengths, runaway, and child substance use needs domains contained the largest percentage of items that should or should not have been marked actionable. For families receiving the FAST, The Family Together domain had the largest percentage of items that should have been marked as actionable based on notes in the case plan. The percentage of items which should/should not be actionable for both CANS and FAST are generally quite low, which indicates a successful implementation of the initiative.

Comments are determined as missing if a) an item was marked as actionable in the assessment and no comment is present, b) an item should be marked as actionable and no comment was present, or c) the item does not need to be marked as actionable, but there were events in the case notes that should be discussed in the comments section but were not present (*e.g.*, the caregiver is currently in a substance abuse program). The number of cases missing comments tend to follow those domains where more items should have been marked as actionable.

Domain	Percentage Should be Actionable	Percentage Should Not be Actionable	Missing Comments
CANS 0–4 (N = 99)			
Caregiver Strengths and Needs (29 items)	0.8%	0.2%	1.7%
Child Behavioral Health / Emotional Needs (8 items)	1.2%	0.4%	2.5%
Child Risk Factors (10 items)	1.1%	0.1%	2.8%
Life Domain Functioning (11 items)	1.8%	0.3%	5.0%
Preschool/Daycare (5 items)	0.5%	0.0%	4.5%
Regulatory Functioning (2 items)	0.9%	0.0%	4.5%
Strengths (9 items)	2.1%	2.5%	9.9%
Trauma (12 items)	1.8%	0.2%	2.8%
Youth Developmental Needs/Acculturation/Sexual Abuse (12 items)	0.2%	0.0%	0.4%
Caregiver Substance Use Needs (5 items)	2.5%	0.8%	8.3%
CANS 5+ (N = 112)			
Caregiver (29 items)	0.7%	0.1%	1.5%
Child Behavioral Health/Emotional Needs (10 items)	3.6%	0.4%	7.5%
Child Risk Factors (12 items)	1.3%	0.4%	2.4%
Developmental Needs/Acculturation/Sexual Abuse (12 items)	0.5%	0.1%	2.8%
Life Domain Functioning (14 items)	2.1%	0.2%	4.6%
Runaway (9 items)	3.5%	0.6%	6.8%
School (4 items)	0.0%	0.0%	0.1%
Strengths (14 items)	0.2%	0.0%	2.0%
Substance Use Needs (5 items)	2.7%	3.0%	10.5%
Transition Age (12 items)	0.9%	0.1%	1.3%
Trauma (12 items)	2.1%	0.3%	3.8%
FAST (N = 165)			
Caregiver Advocacy Status	0.5%	0.1%	2.0%
Caregiver Status	0.4%	0.0%	4.7%
The Family Together	1.8%	0.6%	8.9%
Youth	0.6%	0.1%	4.1%

Table 47. Accuracy of the CANS/FAST Initial Assessment

Service Needs

Cases were also reviewed to determine if the services described in the case plan aligned with what should be provided to meet the child/adolescent's specific needs and whether progress had been made on these services. The results of the reviews are summarized in Table 48. Across both CANS assessment age groups, 87 percent of the services offered aligned with the case plan. For children in the 0–4 age group, 94 percent of the services were completed or in progress six months after referral. Eighty-six percent of youth five and older completed or were in progress of receiving the services defined in the CANS. Slightly more than three-quarters of families with a FAST received services that aligned with the case plan and 86 percent of the services were either in progress or received within six months of the referral.

Domain	Percentage of Services that Align with Case Plan	Percentage of Services in Progress or Completed
CANS 0–4 (N = 99)		
Caregiver Strengths and Needs (29 items)	90%	100%
Child Behavioral Health / Emotional Needs (8 items)	100%	100%
Child Risk Factors (10 items)	78%	89%
Life Domain Functioning (11 items)	82%	76%
Preschool/Daycare (5 items)	86%	95%
Regulatory Functioning (2 items)	87%	92%
Strengths (9 items)	88%	100%
Trauma (12 items)	100%	100%
Youth Developmental Needs/Acculturation/Sexual Abuse (12 items)	85%	94%
Caregiver Substance Use Needs (5 items)	90%	100%
CANS 5+ (N = 112)		
Caregiver (29 items)	79%	91%
Child Behavioral Health/Emotional Needs (10 items)	88%	78%
Child Risk Factors (12 items)	89%	87%
Developmental Needs/Acculturation/Sexual Abuse (12 items)	90%	90%
Life Domain Functioning (14 items)	92%	86%
Runaway (9 items)	71%	86%
School (4 items)	88%	88%
Strengths (14 items)	83%	67%
Substance Use Needs (5 items)	75%	50%
Transition Age (12 items)	85%	87%
Trauma (12 items)	86%	86%
FAST (N = 165)		
Caregiver Advocacy Status	73%	90%
Caregiver Status	78%	82%
The Family Together	81%	86%
Youth	78%	86%

Table 48. Services in Case Plan Match Childs Needs and Progress on Services for Initial Assessment (Percentage)

Discussion

Success and Strengths

Services Provided

DCFS staff have noted that the CANS/FAST tool has changed how workers think about assessment. For instance, one FSW Supervisor said, “There has been a shift in critical thinking skills, and a better determination of what is an emergency and what is a risk factor.” At the same time, staff acknowledge that there has been little change in the services DCFS offers families. DCFS staff have identified an array of services that families need but are not readily available in many communities. For instance, specialized parenting classes for children with autism, support groups for people who are grieving,

laundry vouchers, and transportation assistance such as bus passes are examples of specialized services that are often identified as service needs but are not readily available in communities. Services that have been readily available pre- and post-implementation include basic needs (*i.e.*, cash assistance, food, clothing, shelter), parenting education, mental health counseling, medical services, and substance abuse services.

Satisfaction with Program

Engagement with children and families is an oft-cited benefit of the CANS/FAST assessment. The CANS/FAST assessment helps staff learn more pertinent information about the children and/or families and subsequently plan for more appropriate services tailored to their needs. Some DCFS Area Directors and Supervisors report that the CANS/FAST forces FSWs to think more about their case plans because they have to comment about the rating they give families. Since CANS/FAST implementation, staff reported better identification of needs and services to offer families. While there is consensus among staff that completing the CANS/FAST is time consuming, they also report it offers a more thorough assessment, which translates into a better case plan. A major area of dissatisfaction is the requirement for annual CANS/FAST recertification for DCFS staff, which is time consuming and impacts staff getting work done in a timely manner.

Challenges

Programmatic

High caseloads and staff turnover were reported as significant problems associated with completing the CANS/FAST assessment. When new staff are hired, it is a long process before they are trained and ready to hold a full caseload. Staff using the CANS/FAST assessments are required to take the web-based CANS/FAST certification test created by Dr. Lyons and pass with a score of 80 percent or above in order to become certified. A few staff mentioned that the certification process is challenging because some staff have test anxiety. One FSW Supervisor stated that the certification process “puts people who already have high pressure jobs under more unnecessary pressure. If they [the worker] don’t pass, someone has to pick up that caseload until they do.”

Staff Experience

Staff have expressed that the CANS/FAST is more challenging and time consuming than the previous assessment tool, the FSNRA. For families where multiple children are in care, FSWs are required to complete a separate CANS assessment for each child in the family, which can be a lengthy process. As a result, supervisors must be vigilant and monitor the work of staff to ensure they are not copying and pasting information from previous assessments into the tool or across siblings as opposed to individualizing each assessment. Time management is also a concern because some FSWs complete the

CANS/FAST tool on paper as they meet with families and then go back to the office to enter it on their computer.

Many staff have reported concerns regarding correctly scoring the CANS/FAST assessments. Most of the questions on the tool are subjective, which makes scoring the tool difficult. One Area Director mentioned that you have to think like Dr. Lyons to determine whether a child or family should receive an “actionable” or “un-actionable” score.

Implications

The CANS/FAST assessments are interactive engagement tools designed to identify the strengths and needs of families. When the tool is sufficiently completed, there should be adequate information upon which to develop a thorough and family-specific case plan, identifying needed services up front to reduce the likelihood of families returning to the child welfare system. Staff believe the CANS/FAST tools are more directed and specific to the needs of individual children and families; therefore, supervisors must be more involved in the case to ensure workers are completing quality assessments. DCFS supervisors are working to ensure that all staff maintain a current CANS/FAST certification, ensuring they can effectively complete the tools and thus assess the service needs of children and their families. Active steps are ongoing to ensure that workers are providing families with the correct services based on their needs and what is available in the community.

Outcome Study

Comparison/Cohorts

The comparison group for CANS outcomes is drawn from a historical pool of children who were in care for at least 90 days one year prior to CANS implementation with a completed FSNRA. A single comparison pool contains 2,099 children; however, the treatment group contains over or near that number of children. To select comparison groups which are similar in nature to the treatment groups, a “reverse” PSM technique was used where the members of the treatment group were matched to the comparison group. Due to the comparison and treatment groups being roughly equal in size and based on significant differences in the characteristics between the two groups, every other treatment group member was matched to the comparison group. The variables used to determine propensity scores were service area, gender, age at the time of the initial assessment, race, ethnicity, and allegation(s) of the case associated with the child’s removal. Propensity scores were matched using a nearest neighbor algorithm. Table 49 shows the number of children in each cohort by the type of initial CANS assessment given (0–4 or 5+). The final reporting period was not matched since not enough time has passed to measure outcomes.

Cohort	Age at CANS	Total
Comp (2/14 – 1/15)	0–4	1,078
	5+	1,021
Cohort 1 (2/15 – 7/15)	0–4	575
	5+	475
Cohort 2 (8/15 – 1/16)	0–4	559
	5+	491
Cohort 3 (2/16 – 7/16)	0–4	548
	5+	502
Cohort 4 (8/16 – 1/17)	0–4	531
	5+	519
Cohort 5 (2/17 – 7/17)	0–4	539
	5+	511
Cohort 6 (8/17 – 1/18)	0–4	560
	5+	590

Table 49. Number of CANS Cases by Age

The FAST comparison group was selected from a pool of protective and supportive service cases opened between February 1, 2014 and January 31, 2015, opened for at least 90 days with a FSNRA completed for the case. Propensity scores were generated using service area, number of male children, number of female children, average age of the children, the race of the family and the ethnicity of the family.

The comparison pool is roughly the same size as the treatment groups. To ensure the best possible match, every-other treatment member was matched to effectively double the comparison pool size. Only matched treatment group members were used in the analysis. Table 50 shows the number of cases for the treatment and comparison groups. As with the CANS, a comparison group was not generated for the final FAST cohort as not enough time has passed to measure outcomes.

Cohort	Number of Treatment Cases	Number of Comp Cases
Cohort 1 (2/15 – 7/15)	2,194	1,093
Cohort 2 (8/15 – 1/16)	2,167	1,078
Cohort 3 (2/16 – 7/16)	2,207	1,100
Cohort 4 (8/16 – 1/17)	1,793	893
Cohort 5 (2/17 – 7/17)	2,022	1,005
Cohort 6 (8/17 – 1/18)	1,907	950
Cohort 7 (2/18 – 7/18)	1,898	—

Table 50. Number of FAST Cases for Tx and Comp Groups

Results

CANS

Permanency

A primary goal of the CANS assessment is to ensure that children in foster care achieve permanency in the shortest time possible. Table 51 shows the percentage of children who were discharged within three, six, and twelve months of the initial CANS broken out by cohort, age group, and discharge destination. Outcomes are reported when sufficient time has passed; statistically significant outcomes are highlighted. In the fifth reporting period, significantly more youth achieved reunification or were placed in relative custody within twelve months of the initial CANS for both age populations. Additionally, in the sixth reporting period, youth older than five were significantly more likely to be reunified within three and six months of the initial CANS.

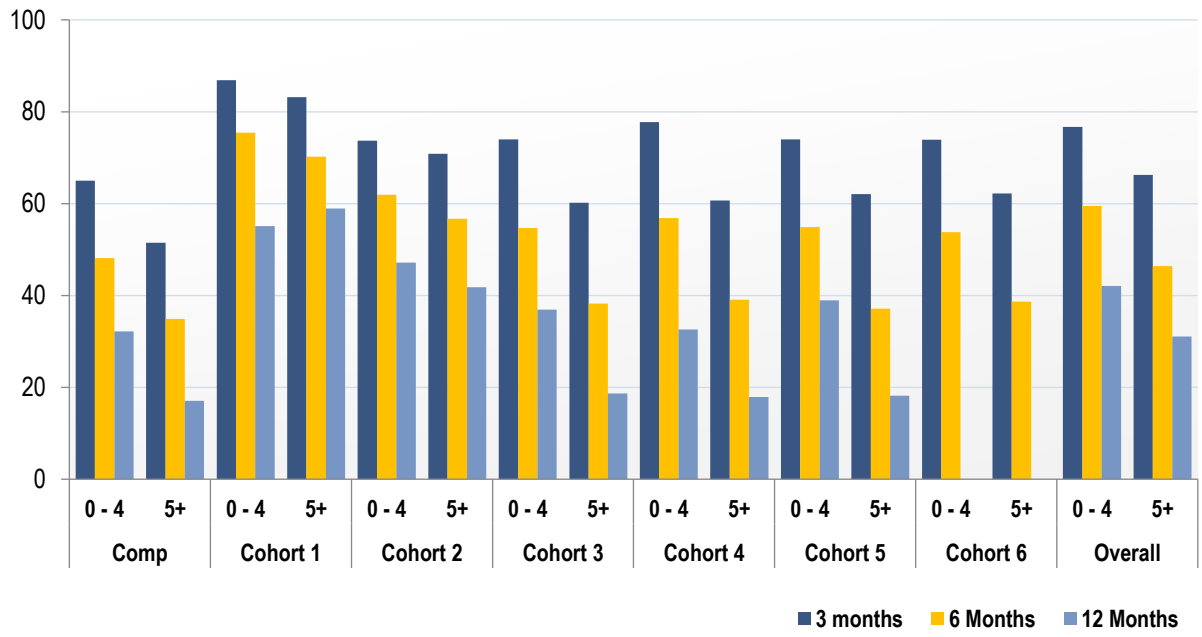
Time Frame	Age	Reunified/Placed with Relatives			Aged Out			Adoption			Other Permanency		
		3 Mo	6 Mo	12 Mo	3 Mo	6 Mo	12 Mo	3 Mo	6 Mo	12 Mo	3 Mo	6 Mo	12 Mo
Comparison	0–4	3.1	15.3	37.6	—	—	—	0	0.5	3.6	0.3	0.6	1.0
	5+	3.1	15.2	36.3	0.2	1.3	2.5	0	0	0.8	0.3	1.6	3.3
Cohort 1	0–4	11.5	20.2	35.7	—	—	—	1.7	7.1	19.0	0.2	0.2	0.3
	5+	10.1	19.6	30.3	2.3	3.4	6.1	2.9	4.8	10.1	3.2	4.4	8.2
Cohort 2	0–4	11.2	19.2	35.3	—	—	—	0.7	1.8	8.2	0.5	1.1	1.6
	5+	15.9	24.2	39.5	1.0	1.4	3.1	0.2	1.7	5.4	1.0	1.9	4.1
Cohort 3	0–4	9.7	20	38.8	—	—	—	0.2	1.1	5.0	0.6	0.6	0.6
	5+	15.6	30.1	48.3	0.2	0.6	1.4	0.2	0.4	1.8	0.6	1.0	2.0
Cohort 4	0–4	10.9	22.6	42.4	—	—	—	0	0.6	3.3	0.4	0.6	1.5
	5+	13.6	27.9	46.6	0.4	0.8	1.2	0.4	1.2	1.4	0.6	1.0	2.5
Cohort 5	0–4	8.7	18.6	45.5	—	—	—	0	0.6	3.2	0.7	1.1	1.7
	5+	10.7	24.4	45.0	0.4	0.8	2.0	0	0	0	0.8	1.2	3.6
Cohort 6	0–4	9.5	17.1	—	—	—	—	0.2	0.2	—	0.7	0.7	—
	5+	12.4	21.2	—	0.2	1.2	-	0	0	—	1.0	2.0	—
Overall	0–4	10.3	19.6	39.4	—	—	—	0.5	1.9	7.9	0.5	0.7	1.1
	5+	13.1	24.6	42.1	0.7	1.3	2.7	0.6	1.3	3.6	1.2	1.9	4.0

Table 51. Percentage of Children Discharged by Reason for Discharge

Placement Stability

To measure the stability of youth in care, Figure 28 shows the percentage of children with no more than one placement change within three, six, and twelve months of the initial CANS assessment. Overall, placement stability at all time frames is significantly better for treatment group youth in both age groups than comparison group youth. Placement stability for both age populations in Cohort 6 remains stagnant at three and six months when compared to prior periods. During the second year of implementation and beyond (*i.e.*, Cohort 3 and on), the percentage of youth with placement stability decreased, particularly for older youth, likely due to the rise in the foster care population.

Figure 28. Percentage of Children with No More Than One Placement Change

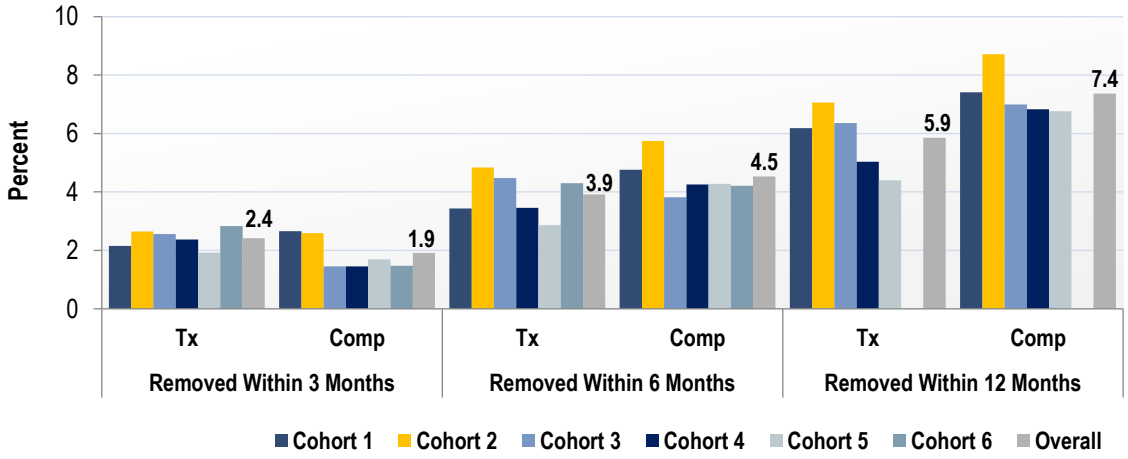


FAST

Child Removals

The percent of cases where at least one child was removed within three, six and twelve months of the initial FAST assessment for the treatment group or the FSNRA assessment for the comparison group are shown in Figure 29. Outcomes are reported when enough time has passed. Families with a FAST are less likely to have a child removed within twelve months than families receiving an FSNRA, with families in Cohort 5 being significantly more likely to keep all youth safely in the home. For three- and six-month outcomes, families were equally or slightly less likely to keep all children in the home after a FAST than those with an FSNRA.

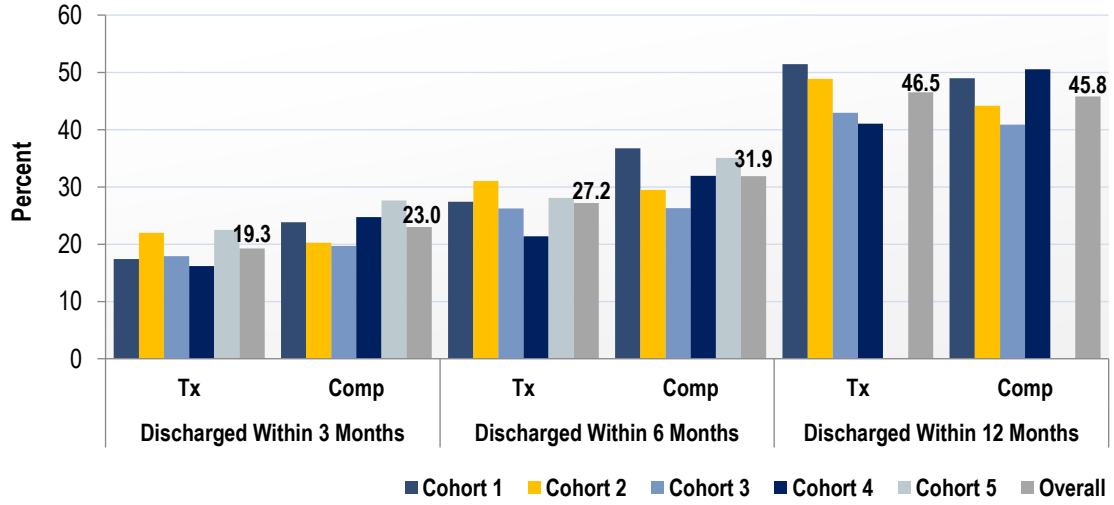
Figure 29. Percentage of Cases with at Least One Child Removed Within 3, 6 or 12 Months



Children Discharged from Care

Figure 30 shows the percentage of children who were removed from their homes within twelve months of the initial FAST assessment who were reunified with biological parents or relatives from care within three, six, and twelve months after entry. In general, youth entering care after a FAST assessment were less likely to be reunified with their families within three and six months than were children in the comparison group. However, a slightly higher percentage of youth removed after a FAST assessment were reunified after twelve months than comparison group youth. These results are not significant.

Figure 30. Percentage of Children Discharge From Care



Discussion

Youth receiving a CANS are significantly more likely to reunify with their biological parents or a relative within three months than comparison group youth and slightly more likely to reunify at six and twelve months. Furthermore, youth are more likely to have placement stability at three, six, and twelve months after a CANS than the previous FSNRA tool. These results imply that the CANS tool is slightly more effective at identifying the youth's strengths and needs than the FSNRA and allows the caseworker to provide more effective case plans.

Families receiving the FAST assessment were slightly more likely to have their children removed within three months than families receiving the FSNRA. This outcome reverses at twelve months where families receiving the FAST are less likely to have their child removed. One theory for these trends is the FAST may identify more serious issues earlier in the life of the case than the FSNRA, but also supports development of a stronger case plan to keep children in the home at longer time frames.

Cost Study

Table 52 displays the cost of room and board payments (for those removed from their homes) and service payments for up to twelve-months following the initial CANS assessment for both treatment and comparison group members for both age ranges. Overall, the treatment group cost nearly $500 less per child under five and nearly $2,000 less per child five and older.

As shown in the CANS outcome evaluation, youth receiving a CANS are significantly more likely to have timely reunifications than those youth who had received an FSNRA. These outcomes manifest themselves in the cost component where treatment group youth under five spend an average of 16 fewer days in substitute care than the comparison group while youth five and older spent 36 fewer days. Both treatment and comparison groups spent roughly similar percentages of nights in foster/congregate care with those ages under five spending 97 percent of their nights in family foster care while those ages five and older spending 66 percent of the nights in that setting. Thus, by reducing the total number of nights youth spent in care, the cost per child for CANS is lower than the cost for the FSNRA, particularly for older youth who tend to incur a higher rate of congregate care placement.

Cohort	Total Number of Children	Total Foster Care Costs	Total Congregate Care Costs	Total Service Costs	Average Cost per Child
Ages 0–4					
Comparison	1,078	$3,805,234.59	$1,020,760.58	$31,595.12	$4,506.11
Treatment 1	575	$1,797,733.14	$366,348.92	$8,132.69	$3,777.76
Treatment 2	559	$1,889,275.26	$313,796.20	$8,157.96	$3,955.69
Treatment 3	548	$1,854,361.02	$435,297.22	$11,729.71	$4,199.61
Treatment 4	531	$1,743,058.41	$333,992.08	$1,689.00	$3,914.76
Treatment 5	539	$1,746,762.66	$590,566.62	$16,533.26	$4,367.09

Cohort	Total Number of Children	Total Foster Care Costs	Total Congregate Care Costs	Total Service Costs	Average Cost per Child
Treatment Total	**2,752**	**$9,031,190.49**	**$2,040,001.04**	**$46,242.62**	**$4,039.77**
Ages 5+					
Comparison	1,021	$2,596,374.07	$10,172,860.20	$97,625.24	$12,602.21
Treatment 1	475	$1,007,208.22	$4,290,647.28	$27,473.31	$11,211.22
Treatment 2	491	$1,083,626.51	$4,392,061.00	$31,135.31	$11,215.53
Treatment 3	502	$1,022,022.37	$4,374,362.46	$31,599.69	$10,812.72
Treatment 4	519	$1,149,580.39	$4,145,475.82	$58,285.31	$10,314.72
Treatment 5	511	$1,217,068.62	$3,948,728.86	$33,059.35	$10,173.89
Treatment Total	**2,498**	**$5,479,506.11**	**$21,151,275.42**	**$181,552.97**	**$10,733.52**

Table 52. Maintenance and Service Costs for CANS

Table 53 shows the cost for those families receiving a FAST assessment compared to those receiving an FSNRA. In total, families with the FAST assessment cost an average of $94 less per family than those with an FSNRA. The outcome analysis showed that a slightly lower percentage of treatment group cases had a removal twelve months after the FAST than the comparison group, though those who were removed remained in care for longer (19 nights). Once youth were in substitute care, both treatment and comparison group spent 79 percent of their nights in a foster home setting. Because the same proportion of foster home to congregate care settings were used for both groups and the length of stay for the treatment group was longer, the cost savings presented here is likely due to the FAST reducing the number of youth entering care within twelve months of the assessment.

Cohort	Total Number of Families	Total Foster Care Costs	Total Congregate Care Costs	Total Service Costs	Average Cost per Family
Treatment Group					
1	2,194	$387,318.48	$1,070,273.06	$49,524.83	$686.93
2	2,167	$421,826.30	$1,015,223.00	$85,770.97	$702.73
3	2,207	$461,169.33	$931,724.98	$86,783.21	$670.45
4	1,793	$346,177.32	$497,622.14	$98,364.54	$525.47
5	2,022	$303,568.84	$615,865.76	$79,158.16	$493.86
Total	**10,383**	**$1,920,060.27**	**$4,130,708.94**	**$399,601.71**	**$621.24**
Comparison Group					
1	1,093	$237,099.79	$546,917.46	$38,782.55	$752.79
2	1,078	$297,886.20	$624,009.26	$42,206.96	$894.34
3	1,100	$226,654.97	$462,985.12	$41,004.15	$664.22
4	893	$159,752.11	$367,217.56	$42,065.14	$637.22
5	1,005	$217,085.11	$366,240.34	$29,559.03	$609.84
Total	**5,169**	**$1,138,478.18**	**$2,367,369.74**	**$193,617.83**	**$715.70**

Table 53. Maintenance and Service Costs for FAST

Multiple Initiative Analysis

With more than one initiative implemented under Arkansas's Title IV-E Waiver, the evaluation would not be complete without taking into account that clients could have been served by more than one initiative. The final evaluation has been expanded to identify if families or children who were served by more than one initiative had better outcomes than those served via a single initiative, and which, if any, combination of initiatives yielded the most favorable results.

Table 54 provides a summary of the volume of cases in which families were served by a single initiative as well as those that received services from a different Waiver initiative, prior to the most recent initiative by which the family was served. Since CANS is intended for children who are removed from the home, such cases or children are not considered in this part of the analysis that focuses on the family as the unit of analysis.

Even though fewer families were served by NFA, those that participated in NFA were more likely to receive services from at least one other initiative, most notably having a FAST completed, than families served by the other initiatives. In fact, close to two-thirds of NFA families also had a FAST completed.

Initiative	No Prior Initiative	Prior DR	Prior TDM	Prior NFA	Prior FAST
DR	19,342 (86%)	2,339 (10%)	35 (0%)	45 (0%)	864 (4%)
TDM	1,571 (84%)	78 (4%)	52 (3%)	8 (0%)	159 (9%)
NFA	125 (20%)	79 (12%)	30 (5%)	6 (1%)	394 (62%)
FAST	14,310 (50%)	1,697 (6%)	1,220 (4%)	469 (2%)	10,937 (38%)

Table 54. Number of Cases for each Initiative where Family had Prior Initiatives

Safety in the Home: Maltreatment and Child Removals after an Initiative

A primary goal of the Waiver is to reduce child maltreatment. Table 55 shows the percentage of cases that had a new true report of maltreatment within six and twelve months following the end date of each initiative (*i.e.,* DR closure date, TDM meeting date, NFA graduation date, FAST assessment date). Families who participated in a Team Decision Making meeting following involvement in the NFA program had the greatest likelihood of having a subsequent report of maltreatment within twelve months, though the sample size is relatively small. Overall, families who were served solely or last by NFA had the lowest likelihood of subsequent maltreatment. Families involved with DR or FAST were significantly more likely to have a subsequent maltreatment when preceded by DR, NFA, or FAST.

	No Prior Initiative		Prior DR		Prior TDM		Prior NFA		Prior FAST	
Initiative	6 mo.	12 mo.	6 mo.	12 mo.	6 mo.	12 mo.	6 mo.	12 mo.	6 mo.	12 mo.
DR	3%	5%	9%	13%	9%	11%	9%	13%	11%	15%
TDM	3%	5%	8%	10%	8%	10%	0%	25%	8%	13%
NFA	2%	3%	1%	1%	3%	3%	0%	0%	2%	4%
FAST	5%	8%	9%	12%	6%	8%	10%	12%	7%	9%

Table 55. Percentage of Cases with a New True Report after Initiative Involvement

A second outcome used to measure the impact on families having been involved in one program, as compared to more than one, is the extent to which children remained safely in their home. Table 56 displays the percentage of cases that had at least one child removed within six and twelve months following an initiative. The rates of removal were highest among families who participated in Team Decision-making, regardless if TDM was the only Wavier initiative the family was involved or if they had prior involvement in one of the other initiatives.

Similar to the results observed above for subsequent maltreatment, families who were engaged in NFA had the lowest rates of a child being removed within six and twelve months, with no more than three percent of the families having a child removed regardless of prior initiative involvement. Families who had a DR case open with no other involvement in the Waiver initiatives had low rates of removal within six and twelve months (1% and 2%, respectively) of case closure; however, the rate of removal increased significantly when the family participated in a prior DR, NFA, or FAST. Youth who received a FAST assessment with prior involvement in any initiative were significantly more likely to be removed than receiving only the FAST.

	No Prior Initiative		Prior DR		Prior TDM		Prior NFA		Prior FAST	
Initiative	6 mo.	12 mo.	6 mo.	12 mo.	6 mo.	12 mo.	6 mo.	12 mo.	6 mo.	12 mo.
DR	1%	2%	4%	7%	6%	6%	9%	9%	6%	9%
TDM	12%	13%	21%	23%	10%	10%	13%	13%	16%	19%
NFA	0%	0%	3%	3%	3%	3%	0%	0%	2%	3%
FAST	5%	7%	7%	9%	9%	10%	7%	8%	5%	6%

Table 56. Percentage of Cases with a Child Removed After Initiative Involvement

Child Removal Characteristics: Reunification, Placement Stability, and Placement Location

As observed above, ultimately some cases will have children removed from the home despite the family's involvement in one of the Waiver initiatives. It is important to assess the impact or outcomes of children who are placed into substitute care. In the following, results of the analysis used to measure the impact on children removed is presented, answering the following research questions which were used to assess permanency: What proportion of children are reunified within twelve months? How stable are their

placements? What proportion of children are placed with relatives or need to be placed into higher levels of care, i.e., congregate care? In this section, children who had a CANS completed are included in the analysis.

Table 57 shows the number of children removed from the home within twelve months of initiative involvement. With limited exception, prior involvement with one of the other initiatives did not appear to increase the number of children who were removed from the home. Very few children whose families enrolled in NFA were removed.

Initiative	No Prior Initiative	Prior DR	Prior TDM	Prior NFA	Prior FAST
DR	667 (71%)	166 (18%)	2 (0%)	6 (1%)	96 (10%)
TDM	321 (78%)	25 (6%)	5 (1%)	6 (1%)	57 (14%)
NFA	0 (0%)	2 (9%)	1 (4%)	0 (0%)	20 (87%)
FAST	1,873 (49%)	228 (6%)	201 (5%)	71 (2%)	1,425 (38%)
CANS	363 (62%)	36 (6%)	23 (4%)	7 (1%)	156 (27%)

Table 57. Number of Children Removed for Each Initiative Where Family had Prior Initiatives

Table 58 shows the percentage of children who achieved reunification within twelve months of removal. Half of the children removed after an isolated involvement with DR are reunified within twelve months, with a similar rate of success observed if their family also participated in TDM or NFA. Reunification rates were significantly lower for DR youth with a prior FAST than if receiving DR alone. Children who had a CANS completed following the closure of a DR case were most successful in returning home within twelve months, where this result is statistically significant. Initiatives which are preceded by a FAST assessment are typically significantly less likely to have youth reunified within twelve months.

Initiative	No Prior Initiative	Prior DR	Prior TDM	Prior NFA	Prior FAST
DR	50%	43%	50%	50%	38%
TDM	43%	40%	20%	0%	39%
NFA	—	50%	0%	—	60%
FAST	44%	34%	38%	48%	39%
CANS	41%	61%	43%	29%	28%

Table 58. Percentage of Children Reunified within 12 months After a Removal

Table 59 displays the percentage of children that have placement stability for 120 days after a removal. To account for potential instability at the beginning of a removal (*e.g.*, placement into an emergency shelter), placement stability is measured from the placement the youth is in 14 days following removal. Of the children removed after isolated DR involvement, about a quarter achieve a stable placement after removal. Those that had a prior DR or FAST are slightly less likely to have stability than when they were involved in solely one DR case. Children removed following an isolated TDM involvement achieved the highest rate of placement stability, with 41 percent staying in the placement for at least 120 days; they are also more likely to have a stable placement

if previously involved with DR but less likely if previously involved with FAST. Children removed after a FAST that had no prior initiative involvement achieved placement stability at a rate of 34 percent. They were less likely to have placement stability if they previously had a DR but more likely if previously involved with TDM, NFA, or another FAST.

Initiative	No Prior Initiative	Prior DR	Prior TDM	Prior NFA	Prior FAST
DR	26%	22%	100%	17%	24%
TDM	41%	44%	80%	0%	30%
NFA	—	50%	0%	—	40%
FAST	34%	27%	42%	42%	36%
CANS	38%	22%	39%	14%	38%

Table 59:. Percentage of Removed Children with a 120-day Stable Placement

In addition to having a stable placement, it would be hoped that through each initiative, relatives or fictive kin would be found who could care for the children while the biological parents received necessary services. Table 60 shows the percentage of children who were placed with relatives within three months of removal. Youth removed after a TDM were most likely to be placed with a relative. TDM's model includes relatives in the meeting, therefore, this result is not unexpected. Higher rates of success were also observed for children whose family participated in NFA after having a TDM or DR. Youth are significantly more likely to be placed with a relative if removed within twelve months of a FAST if there was a prior NFA or another prior FAST than with no previous initiative.

Initiative	No Prior Initiative	Prior DR	Prior TDM	Prior NFA	Prior FAST
DR	25%	21%	50%	0%	21%
TDM	34%	36%	20%	50%	39%
NFA	—	50%	100%	—	45%
FAST	27%	24%	32%	41%	31%
CANS	26%	11%	39%	43%	27%

Table 60. Percentage of Removed Children Placed with a Relative within Three Months

To determine if there is a combination of initiatives that effectively reduces congregate care placements, Table 61 shows what percentage of children are placed in congregate care within three months of removal. Children removed after a DR typically show the highest rates of entering congregate care within three months of removal at 59 percent. Furthermore, DR youth whose family received a prior DR are significantly more likely to enter congregate care than with just a single instance of DR. Children removed after a TDM typically showed the lowest rates of entering congregate care. Children removed after a FAST whose family also had a TDM were significantly less likely to enter congregate care than receiving a FAST alone. However, FAST youth who received a prior DR or NFA were significantly more likely to enter congregate care. Interestingly, youth who received a DR prior to any other initiative were generally significantly more likely to be placed in congregate care than receiving only that initiative.

Initiative	No Prior Initiative	Prior DR	Prior TDM	Prior NFA	Prior FAST
DR	59%	70%	50%	83%	66%
TDM	19%	32%	20%	17%	33%
NFA	—	50%	100%	—	35%
FAST	36%	59%	27%	49%	38%
CANS	34%	56%	17%	14%	37%

Table 61. Percentage of Removed Children Placed in Congregate Care within Three Months

Discussion

When looking at recurrent verified maltreatment reports and occurrences of child removal, in general families who received multiple initiatives were less likely to have safety in the home than families who received a single initiative. This result is initially counter to the hope that multiple initiatives would have a positive effect on safety in the home. However, it is likely that the families that need the most help (*i.e.*, least likely to have safety in the home) are successfully receiving assistance from more than one initiative.

When looking at placement outcomes for children removed from the home (*i.e.*, reunification, placement stability, placement with relatives, placement in congregate care), certain combinations of initiatives were associated with better results. Reunification rates were typically lower if a child was involved with multiple initiatives, with the exception of a CANS preceded by involvement in DR or TDM. Rates of placement stability, placement with relatives, and placement in congregate care were all improved by involvement with TDM. That is, if a removed child received a TDM as a recent or prior initiative, they were generally more likely to have 120-day placement stability and be placed with relatives, and less likely to be placed in congregate care.

In summary, while families and children receiving multiple initiatives typically have worse outcomes than families receiving one initiative, involvement with TDM is often associated with improved placement outcomes for children removed from the home while prior involvement with DR often resulted in underperforming outcomes.

Summary and Recommendations

Summary

Arkansas's IV-E Waiver is unique from Waiver Demonstration Projects in other States due to the implementation of six separate initiatives with multiple target populations. Each of the initiatives has required careful planning within the Central and local offices, engagement and buy-in of staff and stakeholders, ongoing messaging and communication to staff and community stakeholders, contracts with community partners, hiring and training of staff across the state, and enhancements and changes to Division policies and the CHRIS system while implementing evidence-based models with fidelity. The State has made strides in putting programmatic components in place so that children and families are served, and desired outcomes are achieved.

Program/Policy Lessons Learned and Recommendations

Differential Response

Because Differential Response was in place in some Areas before the start of the Waiver period, the State enjoyed a relatively smooth implementation, adaptation of the initiative, and positive preliminary outcomes. Recommendations pertain to program training and capacity.

1. Consider implementing wider training initiatives on DR so that non-DR staff can provide back-up and/or support to DR Specialists. Currently, many non-DR staff are not aware of DR and how it fits into the larger goals of the agency.
2. Build awareness of DR within local communities so that stakeholders and partners can understand the purpose of DR as a program so that support and availability for common service needs can increase.

Team Decision-Making

The TDM initiative experienced delayed and partial implementation and encountered significant challenges that have impacted the success of the initiative. Recommendations speak to some of these challenges, while considering the political and logistical environments in which TDMs are implemented.

1. Staff buy-in and organizational readiness regarding when to create a protection plan and the purpose of the TDM have been challenges. The State can address this by developing and disseminating best practices for planning for and scheduling a TDM that highlight how a TDM can benefit a family. Staff who plan and participate in TDMs should be encouraged to build relationships with staff and community partners in order to increase likelihood of a TDM resulting in successful follow-up.

Nurturing the Families of Arkansas

NFA has been successfully integrated into services throughout the state, and staff and community partners are engaged and in support of the program. Recommendations for NFA pertain to capacity and eligibility criteria.

1. For future projects of similar scope, the State should develop a plan for increasing capacity to serve more families, especially if the goal is to serve all families with a need for a parenting program (who meet the criteria).
2. There have been conflicting messages regarding the eligibility criteria pertaining to substance use. Caregivers currently using substances were originally disqualified from receiving NFA. However, criteria have been softened to exclude only caregivers for whom substance use would interfere with successful participation in NFA; caregivers with less severe use would be permitted to join. This criteria change was not consistently or assertively messaged to DCFS staff (those making program referrals). The State should re-establish criteria guidelines and message consistently throughout all Service Areas.

Targeted Recruitment

The Targeted Recruitment initiative has experienced barriers related to staffing, including the hiring, role, and responsibility of Community Engagement Specialists, Area readiness, and project messaging. Programmatic recommendations pertain to project management and the need for discrete project goals.

1. Central Office staff should provide robust direction and guidance on how, when, and where Targeted Recruitment activities should occur, and should increase accountability measures to CESs.
2. The number of inquiries that come into the case management (or similar) system after a recruitment event occurs should be tracked. This information can be tracked at the county level to determine which events/strategies work well in different regions across the state, since recruitment strategies change depending on the demographics of each region.
3. Customer service training should be provided to caseworkers in an effort to underscore the importance of rapid response to foster families for the retention of homes.
4. One or two staff should be hired to serve as a “Foster Parent Hotline,” to respond to questions from foster parents about procedural questions (*e.g.*, how to fill out certain forms) or formal questions (*e.g.*, where is the closest day care).

Permanency Roundtables

The PRT initiative has experienced challenges in implementation and provision of services to the target population of youth in-care for 18 months or more and was ultimately discontinued. Data available on preliminary outcomes can be used to make informed programmatic changes and improvements. To the extent Permanency Roundtables are reconsidered for implementation, recommendations pertain to implementation planning and policy.

1. Guidelines for the age and circumstances of youth that should receive priority for a PRT should be refined, and how they may affect intended outcomes.
2. A standard number of PRTs that should be conducted each month or quarter based on each Service Area's percent of the statewide target population should be established.
3. Accountability and documentation requirements need to be established, along with a statewide plan for continuous quality review and improvement.
4. The State PRT Coordinator should not be required to attend each PRT throughout the state. This practice is not feasible or effective. Instead, more staff need to be trained in each Area to conduct meetings and fulfill PRT roles and responsibilities.

CANS/FAST

The CANS/FAST initiative has been implemented universally to children, youth, and families across the State, and the tool is being effectively used and documented in CHRIS. Recommendations for CANS/FAST are centered on communication and support.

1. Messaging on the use of the CANS/FAST as a communication tool needs to occur frequently, providing ongoing guidance on how the assessments differ from the FSNRA, the use of meaningful and pertinent comments, and how to gather necessary information about the family or child so that scoring for strengths and needs is done appropriately.
2. Training and recertification should increase and be improved. DCFS should consider offering interactive modules where staff can practice and receive feedback on assessment scoring. Support should be ongoing and throughout the year to keep staff skills sharp and to improve the accuracy and fidelity of the assessments. "Tiers" of support might also be considered so that less experienced or less confident staff can access more intensive support and guidance.

Evaluation Lessons Learned

Evaluation activities and findings of the Arkansas IV-E Waiver evaluation have shed light on key lessons learned, providing recommendations regarding evaluation design and implementation.

1. It was necessary to adapt and refine data collection protocols and their implementation according to the reality of project implementation, the extent to which initiative-specific details were documented, the availability of data in CHRIS, and the extent that available data could be used to answer research questions. For ARCCC in particular, it was found that focus groups were not the best medium to hear the voices of foster parents, but rather one-on-one interviews with each family which allowed for a more relaxed and comfortable environment for the families to attend on their own time.
2. There are an increasing number of opportunities to use evaluation findings to inform data-driven programmatic decisions. Evaluation design should continue to consider process and outcome evaluation questions that may have local significance and can be used to serve a specific function in program management or implementation design. For example, the CANS/FAST case review tools were redesigned to capture the process components of the assessment tools that were of considerable import to DCFS, that is, the extent to which assessments are completed using pertinent and meaningful information to the family or child. DCFS has its own process for gathering this information but redesigning the case review tool allowed for that process to be more uniform, semi-quantitative, and streamlined.
3. Not all components of the evaluation plan were executed within the first ten quarters of the Waiver period. In the upcoming year, efforts should focus on evaluating well-being for NFA and Targeted Recruitment and building a model for propensity score matching. Additionally, evaluation analysis should begin to capture the impact of the Waiver as a whole on targeted populations. As sample sizes increase, specific evaluation questions pertaining to the impact of receiving multiple Waiver initiatives should be explored.
4. As sample sizes for experimental cohorts increase, analyses conducted will increase in rigor. Cross tabulations and logistic regression models should be created so that the impact of initiatives on outcomes can be isolated.

Obtaining Evaluation Reports

Agencies and individuals interested in receiving a copy of the Interim Evaluation Report or findings included within the semi-annual reports should contact DCFS to request a copy.